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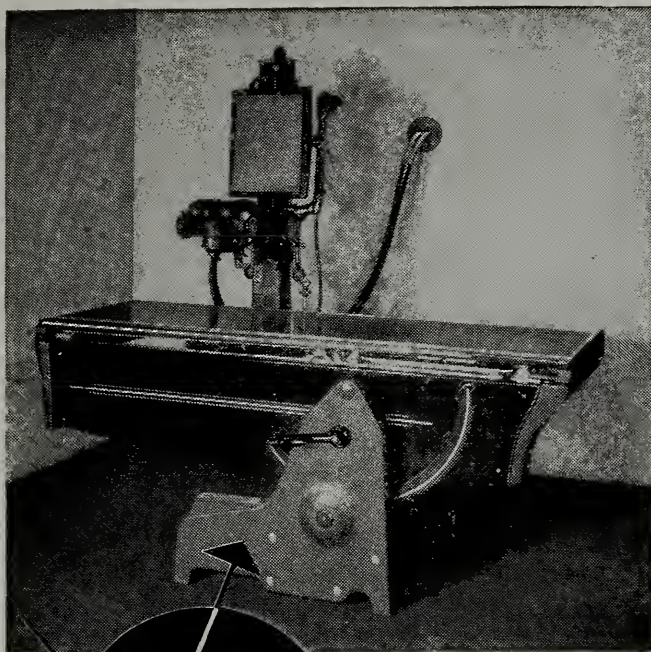
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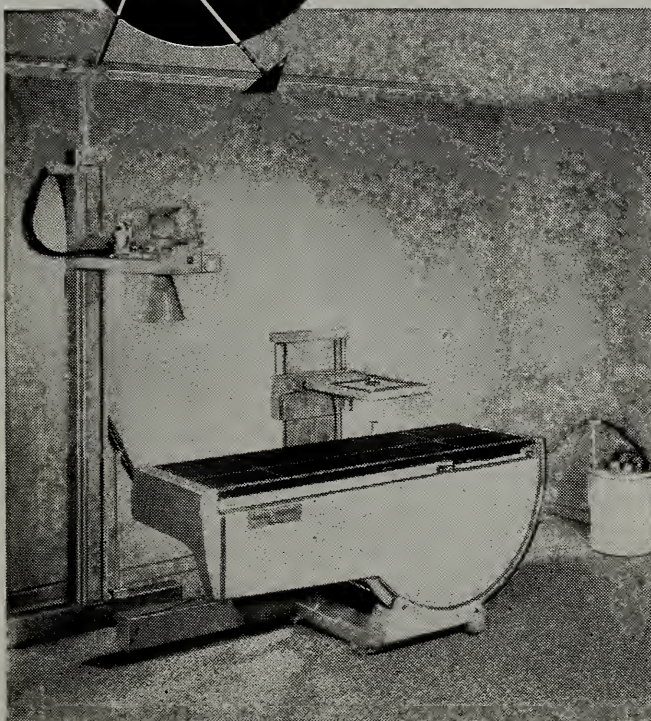
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The Physician's Bookshelf

(Books received from publishers. *The Journal* is not obligated to list herein every book received. It will try to list those which appear to be of greatest interest.)

* * *

A History of Public Health, by George Rosen, M. D. (\$5.75, *MD Publications, Inc.*, New York 22, N. Y.) This book is one of a series being produced under the editorial direction of Felix Marti-Ibanez, M. D., professor and director of the Department of History of Medicine, New York Medical College, the author of which is professor of public health education at Columbia University.

The book traces the course of public health actions from the earliest civilizations on record through Classical Greece, Imperial Rome and the Medieval World of today's forward-looking countries where the most advanced systems are in use. In the modern period, emphasis is given to the principal centers of public health progress, notably, Great Britain, France, Germany and the United States. The men who pioneered the evolution of public health from primitive and ritualistic practices to what it is today also stand revealed.

Among the subjects covered are: disease prevalence, water supply and sewage disposal, maternal and child health, epidemiological theory, occupational health, health education, public health administration, communicable disease control, statistics, public health and public policy, medical geography, public health nursing and international health.

A Textbook of Clinical Neurology With an Introduction to the History of Neurology, by Israel S. Wechsler, M. D. (\$11.00, Eighth edition, *W. B. Saunders Company*, Philadelphia 5, Pa.)

Sins of Their Fathers, by Marjorie Rittwagen, M. D. (\$3.50, *Houghton Mifflin Company*, Boston 7, Mass.)

Infectious Diseases of Children, by Saul Krugman, M. D., and Robert Ward, M. D. (\$10.00, *The C. V. Mosby Company*, St. Louis 3, Missouri.)

Diseases of the Esophagus, by J. Terracol and Richard H. Sweet. (\$20.00, *W. B. Saunders Company*, Philadelphia 5, Pa.)

Mental Health, by Gladys Engel Lang. (\$2.00, *H. W. Wilson Company*, New York 52, N. Y.)

An Introduction to the Study of Experimental Medicine, by Claude Bernard. (\$1.50, *Dover Publications, Inc.*, New York 10, New York.)

Shock and Circulatory Homeostasis: Transactions of the Fifth Conference November 30, December 1 and 2, 1955, Princeton, New Jer-

sey, by Harold David Green, M. D. (\$4.75, *Josiah Macy, Jr. Foundation*, New York 36, N. Y.)

Diagnostic Anatomy, by Weston D. Gardner, M. D. (\$10.00, *The C. V. Mosby Company*, St. Louis 3, Missouri.)

Ligament and Tendon Relaxation, by George S. Hackett, M. D. (\$6.75, Third edition, *Charles C. Thomas Publisher*, Springfield, Illinois.)

Electrocardiography, by Michael Bernreiter, M. D. (\$5.00, *J. B. Lippincott Company*, Philadelphia 5, Pa.)

Physical Diagnosis, by F. Dennette Adams, M. D. (\$12.00, Fourteenth edition, *The William & Wilkins Company*, Baltimore 2, Md.)

Pediatric Index, by Edwin F. Patton, M. D. (\$13.50, *The C. V. Mosby Company*, St. Louis 3, Missouri.)

The Essence of Surgery, by C. Stuart Welch, M. D., and Samuel R. Powers, Jr., M. D. (\$7.00, *W. B. Saunders Company*, Philadelphia 5, Pa.)

Lumbar Disc Lesions, by J. R. Armstrong, M. D., and H. Osmond-Clarke. (\$12.00, Second edition, *The Williams & Wilkins Company*, Baltimore 2, Md., exclusive U. S. distributors.)

Callander's Surgical Anatomy, by Barry J. Anson, M. A., and Walter G. Maddock, M. D. (\$21.00, Fourth edition, *W. B. Saunders Company*, Philadelphia 5, Pa.)

Clinical Endocrinology, by Karl E. Paschkis, M. D., Abraham E. Rakoff, M. D., and Abraham Cantarow, M. D. (\$18.00, Second edition, *Paul B. Hoeber, Inc.*, New York 16, New York.)

Technic and Practice of Psychoanalysis, by Leon H. Saul, M. D. (\$8.00, *J. B. Lippincott Company*, Philadelphia 5, Pa.)

A Physician Looks at Psychiatry, by Jacques M. May, M. D. (\$3.50, *John Day Company, Inc.*, New York 36, New York.)

Clinical Procedures in Occlusal Rehabilitation, by Charles S. Brecker, D. D. S. (\$16.00, *W. B. Saunders Company*, Philadelphia 5, Pa.)

A Method of Anatomy; Descriptive and Deductive, by J. C. Boileau Grant, M. C. (\$11.00, Sixth edition, *Williams & Wilkins Company*, Baltimore 2, Md.)

Living With Your Allergy, by Samuel M. Feinberg, M. D. (\$1.25, *Keystone Book*, J. B. Lippincott Company, Philadelphia 5, Pa.)

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Washington Roundup

News from the Nation's Capital of Interest to Physicians; Developments in Medical and Health Fields

Hitting at "disturbing increase" in quackery involving false and misleading claims for a variety of vitamins, minerals and other food supplements that cost 10 million Americans over \$500 million a year, HEW Secretary Fleming has called for campaign of public education against such quackery, and praised AMA for its role in fighting such operations. * * *

Medicare head Brig. Gen. Floyd L. Wergeland reports that Medicare program hit a monthly cost of \$9.2 million in October, highest in the two-year history of the operation. * * *

Children's Bureau statistics show that for first time in 22 years infant death rate in U.S. has increased, although increase was slight, from 26 per 10,000 live births in 1956 to 26.3 per 1,000 in 1957. * * *

National Institutes of Health survey is expected to show how research grants from Federal government affect medical schools as a whole. Twenty representative institutions are being visited to evaluate the program. * * *

National Air Pollution Conference heard speakers assert that there are definite links between cancer and air pollution; that automobile exhausts and nuclear weapon testing are sources of potentially dangerous pollution. Surgeon-General Burney told Conference that "lung cancer deaths in larger cities are twice those in non-urban areas." * * *

There were an estimated 890 million physician visits, about two-thirds of them in offices, during fiscal year of July 1957 to June 1958, according to first report of National Health Survey recently released by Public Health Service. About 75 per cent involved diagnosis and treatment, as compared with 25 per cent preventive measures. * * *

AFL-CIO is urging a nationwide, uniform, voluntary blood bank system set up under auspices of Joint Blood Council. Proposed system would include uniform mandatory licensing standards and national clearing house or exchange for blood and blood credits. Council consists of AMA, AHA,

American Society of Clinical Pathologists, Red Cross and American Association of Blood Banks. * * *

National Office of Vital Statistics figures show substantial drop in incidence of 10 diseases during 1957 compared with 1956. They are brucellosis, diphtheria, encephalitis, hepatitis, malaria, polio, psittacosis, trichinosis, tuberculosis and typhoid fever. In reverse of a steady decline, number of syphilis cases rose from 131,763 to 136,039. * * *

"Cytoanalyzer," electronic device for speeding up mass screening, at low cost, for uterine cancer, is reported to have passed its first trial. Dr. John C. Pruitt of National Cancer Institute reported that of 1,075 negative smears and 20 positive or suspicious smears fed into the machine, 40 per cent of known negative slides were correctly eliminated as totally negative. However, no suspicious or positive smears were missed. Screener was reported more accurate in screening pre-menstrual than post-menstrual specimens. * * *

Four physicians are members of the 86th Congress, including Drs. Walter Judd of Minnesota, Thomas Morgan and Ivor Fenton, both of Pennsylvania, all three reelected, and a newcomer, Dr. Thomas Alford of Arkansas. Dr. Morgan is slated for chairmanship of House Foreign Affairs, first physician to head that important committee in its 136 years. * * *

AMA-sponsored conference on Civil Defense was told by top Civil and Defense Mobilization officials that revised priorities for health care following atomic attack are as follows: (1) Lives endangered by injuries or illness but whose chances of recovery with treatment are good; (2) pregnant women; (3) non-serious sick and injured cases; (4) cases so grave that even extensive treatment probably would be in vain. * * *

Veterans Administration's out-patient care increased sharply in September of 1958 (128,201 treatment cases) over same month for 1957 (114,157). Those cases include fee-basis patients cared for by private physicians and those accommodated in VA hospitals and regional offices.

You and Your Public

Poll Indicates Patients Have Misunderstandings Regarding Hospital Costs and Finances

INFORMATION developed from a public opinion poll shows that there is opportunity for the physician to help his hospitalized patient maintain "peace of mind" by guarding against tensions and annoyances.

The survey was conducted for the United Hospital Fund of New York by Elmo Roper and Associates to determine public attitudes toward hospitals and hospital financing in New York City and the suburban communities.

The poll brought out that it is in this area, not in the area of scientific skills, that a grudge against hospitals seems to develop on the part of the patient. Also, it was developed that considerable cause of such feelings results from lack of understanding.

Patients Need Guidance

To offset this, it is suggested that the physician take time to discuss fully with his patients just what hospitalization involves, hospital routines, policies, and other pertinent data that can help eliminate much of this misunderstanding.

On the other hand, the poll brought out complaints that were the direct responsibility of the hospital. These complaints involved such items as rude personnel and inattentive service, unfriendly atmosphere, poor admittance procedure, poor food, dirt, filth, "won't admit you unless you can pay; ask for money even in an emergency."

Complaints were, however, in the minority (42 per cent) of the 1405 persons interviewed. Whether they were real or imaginary, they involve the well-being of the patient. The argument that these are hospital problems, and do not involve the physician, are not sound. Remember: Mr. Jones is Dr. Smith's patient, not the hospital's patient. And if Dr. Smith tells Mr. Jones in their pre-hospitalization talk, "Don't hesitate to tell me if you don't like the way they treat you," he is letting the patient know that he stands behind him.

Insurance Misunderstood

In another aspect of the poll, conducted in the New York City area by a professional firm, it was developed that a majority of the persons having hospitalization insurance didn't know what it covered or what it cost. Eleven per cent thought their hospital insurance was too high, 58 per cent

thought it reasonable, five per cent thought it really quite low and 26 per cent didn't know or did not answer.

Fifty-three per cent thought hospital bills too high, 30 per cent, reasonable; one per cent, quite low, and 16 per cent, didn't know or had no answer.

In comparison, 44 per cent thought their doctors' bill too high, 43 per cent, reasonable; two per cent, quite low, and 11 per cent, no answer or didn't know.

It also was noted that 29 per cent thought that Blue Cross covered doctors' bills, and six per cent thought Blue Shield covered hospital bills.

"Blues" Confused

The pollsters commented "There is widespread confusion between Blue Cross and Blue Shield. It is probable that some people think they have Blue Shield but don't, since practically equal numbers called insurance for doctors' and surgeons' bills Blue Cross and Blue Shield."

On the other hand, a majority of those interviewed appeared not to expect insurance to cover the entire hospital bill. While 55 per cent of the city and 65 per cent of the suburban residents said this was because insurance isn't supposed to cover the entire bill, 10 per cent thought that hospitals increased charges to patients with insurance, and an equal number thought that practice was the reason they had to pay part of the bill.

Results of the poll also indicated that to most persons, a hospital is a hospital. Those interviewed apparently made no distinction among voluntary, public and proprietary hospitals.

The group was evenly divided on the question of whether hospitals make money, break even financially or lose money. About one fourth admitted they just didn't know.

To sum up the poll, those interviewed were of the consensus that the best thing about hospitals is the doctors and the worst thing is the handling of arrangements to pay bills.

Personnel Challenged

The firm conducting the poll stated in its report, "With few exceptions, people's opinions about hospitals stem from face to face experiences in hospitals. Hospital personnel, accordingly, have a

Exactly how does new Halodrin* restore the “premenopausal prime” in postmenopausal women?

Webster defines “prime” as the period of greatest health, strength, and beauty. In a woman, these are the childbearing years between puberty and menopause—the years when her hormone production is highest.

The inevitable reduction in this hormone production as she enters the menopause often results in physical discomfort in the form of hot flushes, nervousness, insomnia, or a multiplicity of other symptoms with which you are familiar. Superimposed on this physical picture is the psychic trauma brought on by this unavoidable evidence of aging. The thing that brings her to a physician is simply that she “feels bad.”

You can't make her 35 again—but the odds are good that you can make her feel like it! The secret is a combination of reassurance and hormones. The exact form and amount of the former defy objective analysis, but the latter can now be provided with scientific precision. Reduced to essentials, here is the explanation of exactly how hormones—in the form of Upjohn's new Halodrin—restore the “premenopausal prime.”

The normal premenopausal woman excretes estrogens in the urine in the form of estradiol, estrone, and estriol, in an approximate 28-day average ratio of 39:15:46. Starting with this urinary excretion of estrogens, it is possible to calculate backwards and estimate the amount of estradiol that must have been secreted endogenously in order to produce these urinary levels. This is possible because the proportion of estrogens which appears in the urine following parenteral administration has been established in castrated women.

On this basis, the average endogenous output of estrogens is about 160 micrograms per day during a menstrual cycle, and 80 micrograms per day in postmenopausal women (see chart opposite). Therefore, the restoration of the “premenopausal prime” in the postmenopausal woman requires the replacement of approximately the equivalent of the 80 micrograms of estradiol per day that she no longer secretes endogenously.

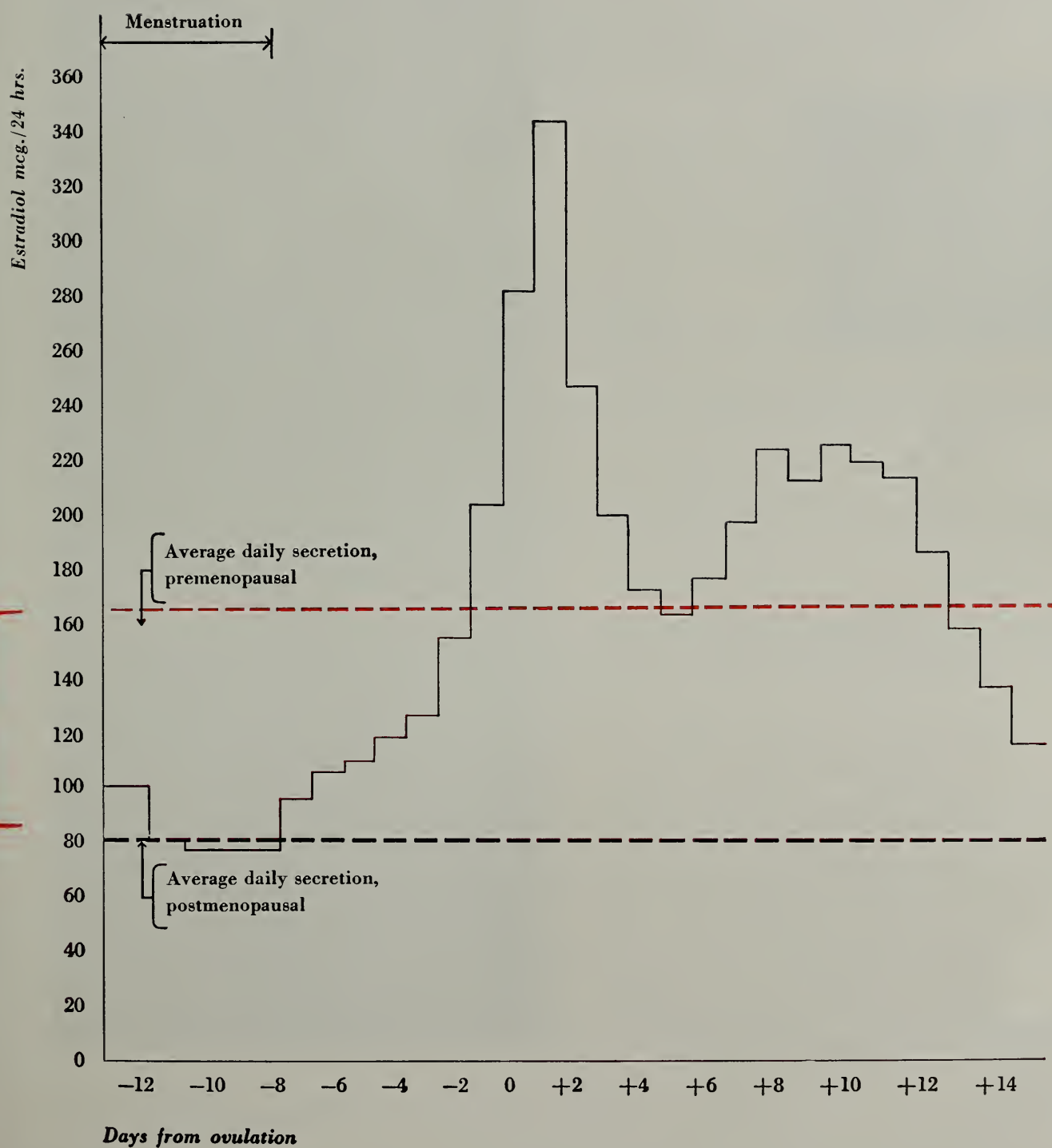
Oral ethinyl estradiol is about 2 to 2½ times as potent as parenteral estradiol. Therefore, the replacement of 80 micrograms of endogenous estradiol production per day is accomplished by the oral administration of 32 to 40 micrograms of ethinyl estradiol per day.

Each Halodrin tablet contains 20 micrograms of ethinyl estradiol, which means that the recommended dosage of 2 tablets per day provides 40 micrograms of ethinyl estradiol. This offsets the loss of 80 micrograms of endogenous estradiol production in the menopausal woman; i.e., restores the “premenopausal prime.”

Each Halodrin tablet also contains 1 mg. of Upjohn-developed Halotestin* (fluoxymesterone)—the most potent oral androgen known. The primary purpose is to “buffer” the ethinyl estradiol just enough to prevent breakthrough bleeding, which is obviously undesirable in the menopause. It also exerts other beneficial hormonal effects, one of which, in common with ethinyl estradiol, is a powerful anabolic action so desirable in patients of advanced years.

Upjohn

Endogenous estrogen secretion (mcg./24 hours)
 (calculated from average 24-hour urinary excretion
 of estradiol, estrone, and estriol)



challenging opportunity to influence public opinion without going beyond the walls of the hospital.

"The present status of opinion, while generally favorable, leaves substantial room for improvement. The primary source of opinions about hospitals lies in personal interaction within the walls of the hospital. The focus of negative opinion about hospitals lies in the areas of personal interaction within hospitals."

Pathologists Adopt Fee-For-Service Policy in Third-Party Relations

According to an article in the *Ciba Medical News*, the nation's pathologists have moved to put their specialty strictly on a fee-for-service basis.

Acting through two organizations—the College of American Pathologists and the American Society of Clinical Pathologists—they have formulated a statement of principles which assert that bills must be submitted in the pathologist's own name, rather than the name of a third party.

The code, officially adopted by both national groups meeting in Chicago recently, specifies that:

Fees for services must be collected in the name of the pathologist either by him or by someone designated by him as his collecting agent. Such fees must include all costs incidental to pathology services.

Institutions, organizations or nonmedical persons must not contract to sell the services of a pathologist.

Prepaid pathology services must be arranged through medical service contracts rather than hospitalization plans.

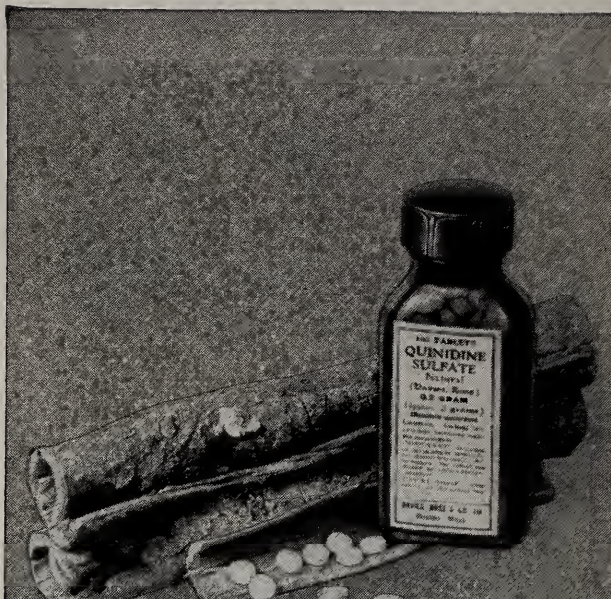
The only exception to the direct-payment requirement is a provision that pathologists may be paid by an institution or the Government for services involved in research or teaching, if the patients are not charged.

The pathologists intend to enforce their decision through a code of penalties. The Executive Committee of the College is slated to meet to consider ways of implementing their new code.

Survival in a Nuclear Crisis Is Television Subject

The National Broadcasting Company and the Educational Television and Radio Center of Ann Arbor, Michigan, in cooperation with OCDM, are presenting an educational TV program series, "Ten for Survival," over NBC's regular network facilities on Tuesdays from 10:30 to 11:00 p. m. EST.

This program series explores modern natural disaster, examines individual and group behavior patterns, and shows the increasing importance of knowledge in an increasingly complex society.



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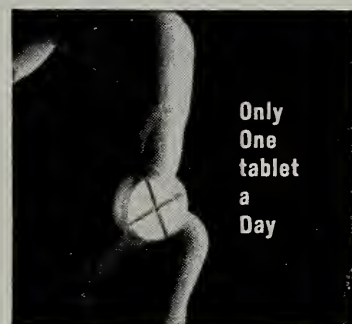
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Dosage: The recommended adult dose is 1 Gm. (2 tablets) the first day, followed by 0.5 Gm. (1 tablet) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours.

KYNEX—WHEREVER SULFA THERAPY IS INDICATED

Tablets: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

Syrup: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

References:

1. Griebble, H.G., and Jackson, G.G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958.
2. Editorial: *New England J. Med.* 258:48-49, 1958.

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*Reg. U. S. Pat. Off.



In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

STATESMANSHIP IN HOUSE OF DELEGATES

It won't be long until the House of Delegates of the Ohio State Medical Association will convene in Columbus—on Monday, April 20, to be exact. That being the case those who will serve in that body should ponder over the recommendations and hopes expressed by Dr. W. B. Harer, a contributing editor to the *Pennsylvania Medical Journal*, in a piece written shortly before the 1958 annual meeting of the Pennsylvania medical society. Wrote Dr. Harer:

"We sincerely hope that, in the coming session, arguments in reference committee hearings and on the floor of the House will be based on cold logic rather than hot temper and will appeal to the intellect rather than to the emotions. We also hope that decisions and policies will be based on the best interests of patients and the entire medical profession rather than selfish considerations and futile personal desires. To the extent to which these hopes are realized we will demonstrate the caliber of and the effectiveness with which we meet the challenge to our statesmanship."

NEW ENCOURAGEMENT FOR FRAUDULENT CLAIMS

A new field in personal injury litigation has been thrown open as the result of a recent decision in the Court of Appeals of New York. (*Ferrara v. Galluchio* 152 N. E. 2d 249 [N. Y., 1958])

The court ruled that Mrs. Eleanor Ferrara was entitled to \$15,000 damages for mental anguish as the result of developing severe cancerophobia.

The crux of the case was her contention that she became extremely fearful of developing cancer after suffering burns while being treated by doctors specializing in x-ray therapy.

In our opinion the majority opinion is a real boner. If upheld and followed, it will encourage floods of fraudulent claims.

This point is taken by the judge who rendered a dissenting opinion, who said:

"The unfortunate result of the rule by this decision, albeit disclaimed, is that a doctor's mere statement as to a possibility is a stepping stone to an increased recovery should the patient simply claim to be concerned to suffer worry by reason thereof. . . .

"The decision of the majority introduces into the

law a new field of damages for cultivation by plaintiffs and affording countless opportunities for fraudulent unverifiable claims."

STRING TO FEDERAL DOLLAR TOO FAR AWAY

Dr. Lowell T. Coggeshall, ex-president of the Association of American Medical Colleges, in an argument in favor of first Federal operational funds for medical schools, made this questionable statement:

"There is no more to fear with Federal than with state tax dollars."

That we doubt. Each tax dollar has a string attached to it. The longer the string the less chance the folks back home have to get in their licks about rules under which the dollar may be spent. We'll take our chances with state tax dollars every time in comparison to the one which has its origin in Washington.

GRANDFATHER CLAUSES NEVER PERMANENT

One of the aggravating gimmicks in licensing legislation is the so-called "grandfather clause." Each time the Ohio General Assembly meets, OSMA representatives have to convince the Assembly that a separate board for licensing of chiropractors would be bad. One of the telling arguments against the bill is the grandfather clause, which clause usually stipulates that those in practice (whether licensed or unlicensed under the present law) may secure a new (and broader) license without an examination.

In a recent issue of the *New England Medical Journal* there appeared an article which throws the spotlight on grandfather clauses, revealing especially the constant battle which ensues to make the grandfather clause less stringent or have it extended indefinitely for the benefit of those who just don't have the intelligence to pass examinations.

Here's the story, in part, from the *New England Journal*:

"In 1951 legislation was adopted defining and limiting the practice of physical therapy by physical therapists.

"To have been eligible under this act for licensure as a physical therapist (a person who practices physical therapy under the prescription, supervision or direction of a person licensed in



in every
arthritic state...

maintenance therapy is still fundamental treatment^{1,2,3}

Sound, conservative therapy with salicylates has been consistently reaffirmed as basic, long-term maintenance therapy in the arthritides.

Buffered Pabirin provides superior maintenance therapy. It epitomizes fundamental long-term basic therapy since it can be given month after month without serious complications and with minimal problems to patient and doctor alike.

Buffered Pabirin is formulated to provide high and sustained salicylate blood levels. Each tablet consists of an outer layer containing a buffer (aluminum hydroxide), para-aminobenzoic acid, and ascorbic acid; a core of acetylsalicylic acid.

In the stomach, the outer layer quickly releases the buffer, which protects against nausea, dyspepsia and other gastrointestinal symptoms so frequently encountered with salicylates alone. The core of Buffered Pabirin then disintegrates rapidly, permitting rapid absorption of the acetylsalicylic acid for faster pain relief.

References: 1. Hart, D.; Bagnall, A. W.; Bunim, J. J., and Polley, F. H.: Ninth International Congress on Rheumatic Diseases, Toronto, Ont. (June 25) 1957. 2. Report of Joint Committee, Medical Research Council & Nuffield Foundation, Treatment of Rheumatoid Arthritis, British Medical Journal (April 13) 1957. 3. Friend, D. G.: New England J. Med. 257:278 (Aug.) 1957.

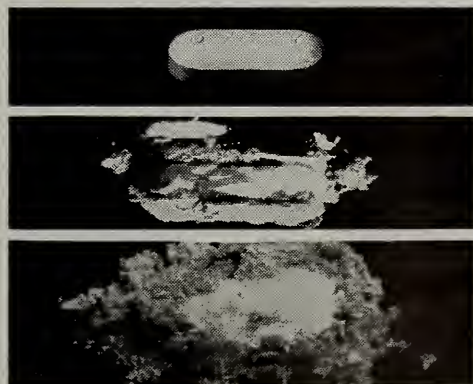
Buffered **Pabirin[®]** *Tablets*

Each tablet contains:

Acetylsalicylic acid (5 gr.)	300 mg.
Para-aminobenzoic acid (5 gr.)	300 mg.
Ascorbic acid	50 mg.
Dried aluminum hydroxide gel	100 mg.

All Buffered Pabirin is sodium- and potassium-free.

Dosage: Two or three tablets 3 or 4 times daily.



*Photographs show 2-stage
Tandem Release disintegration.*

the Commonwealth to practice medicine and surgery), a person must have been at least twenty-one years old, of good moral character, a graduate of an approved high school or its equivalent, and a graduate of a school of physical therapy approved by the American Medical Association or, before 1936, of one approved by the American Physical Therapy Association at the time of his graduation.

"The grandfather clause required the Board of Registration in Medicine to register as a physical therapist any person who applied for registration on or before March 1, 1952, who was a member of the American Physical Therapy Association or the American Registry of Physical Therapists or the Massachusetts Society of Graduate Physical Therapists, or who was practicing for three years immediately before November 28, 1951.

"Unsuccessful attempts to extend that date were made in subsequent years. In 1955, however, the grandfather clause was changed to require the Board to register any person who applied for such registration on or before November 1, 1955, and who was practicing for three years immediately before September 14, 1955.

"This year, a bill was filed to make a few basic changes—such as annual registration of physical therapists—in the 1951 physical-therapy law. The grandfather clause in the proposal provided that the Board *admit to examination* on or before March 1, 1959, applicants who were practicing physical therapy in a competent manner three years before January 1, 1959.

"The bill, as finally passed and signed by the Governor, contains a grandfather clause much different from that contained in the original proposal. The clause now reads:

... the board of registration in medicine shall register without examination any person who on or before December thirty-first, nineteen hundred and fifty-nine and who, on the effective date of this act, (1) was practicing physical therapy in a competent manner in the commonwealth and was so practicing for one of the three years immediately preceding said effective date. . . .

"Enters the grandchild."

PHYSICIAN DARES NOT IGNORE SUBPOENA

"Doctor Ignores Subpoena, Just Misses Night in Jail" read a headline in a Northern Ohio newspaper. Not good publicity for either the individual physician or the medical profession as a whole.

What are the doctor's legal and moral obligations in responding to a subpoena? Here's some information gathered from reliable sources.

A subpoena is a written order commanding a

prospective witness to appear before a certain court at a specified time. It's a "must" order.

Situations in which a physician may be subpoenaed are:

When the patient has quarreled with the doctor over alleged malpractice, non-payment, etc.

When the physician is called by a party opposed to his patient.

Although the subpoena will show the time the witness is to appear, the doctor-witness may not be called on to testify until hours later.

The physician should talk to the attorney and attempt to make arrangements so he can be summoned to the court by a phone call.

If the attorney is unwilling to cooperate the doctor must be at the courtroom on time. Failure to answer a subpoena is contempt of court. The negligent witness may be severely punished.

If the physician is not called within a reasonable period, he should talk with the attorney by whom he was summoned and ask to be put on the witness stand as soon as possible.

If the attorney refuses, the physician may speak to the judge at the first recess. In the event that the doctor's services are needed elsewhere, the judge usually will allow the physician to testify as soon as possible.

GOOD PRESS HAS TO BE EARNED

Says Dr. William F. Quinn, president, Los Angeles County Medical Society:

"You don't get a good press by suddenly pouring on the pressure when you have a particular ax to grind. It is achieved by mutual understanding . . . of the other person's problems and point of view . . . We will have a good press and good public relations only as long as we deserve them."

How are the relations between your county medical society and the press; also radio and TV, if any? Establishing and keeping good relations with communications media are day-by-day chores; not spasmodic ventures to serve a particular purpose.

THE JOURNAL GOT NEW SUIT FOR CHRISTMAS

Did you notice that *The Journal* got a new suit for Christmas? In other words, *The Journal* is sporting a new cover page. Like it?

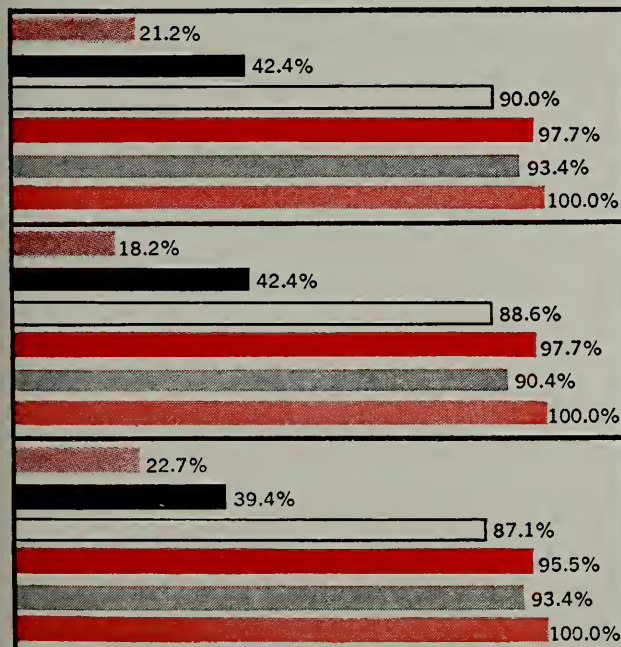
Also, you have noticed that we have been using new type face—and larger—during the past year. We're sure this makes *The Journal* easier to read.

If you have any suggestions as to how we can further improve the appearance of "your magazine," let us know. Also, give us suggestions on content.

in the laboratory:

over 90% effective
against resistant staph

COMPARATIVE TESTS BY THREE METHODS
(DISC, TUBE DILUTION, CYLINDER PLATE)
ON 130 STAPHYLOCOCCI*



Antibiotic A 2-10 units Tao 2-15 mcg.
Antibiotic B 5-30 mcg. Antibiotic D 2-15 mcg.
Antibiotic C 5-30 mcg. Antibiotic E 5-30 mcg.

Percentage of organisms inhibited by the range of concentrations listed for each antibiotic.

Other Tao advantages:

Rapidly absorbed—stable in gastric acid,* TAO needs no retarding protective coating

Low in toxicity—freedom from side effects in 96% of patients treated; cessation of therapy is rarely required

Highly palatable—"practically tasteless"* active ingredient in a pleasant cherry-flavored medium.

Dosage and Administration: Dosage varies according to the severity of the infection. For adults, the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. For children 8 months to 8 years, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective. Since TAO is therapeutically stable in gastric acid, it may be administered without regard to meals.

Supplied: TAO Capsules—250 mg. and 125 mg., bottles of 60. TAO for Oral Suspension—1.5 Gm., 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

References: 1. Koch, R., and Asay, L. D.: J. Pediat., in press. 2. Leming, B. H., Jr., et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 3. Mellman, et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 4. Olansky, S., and McCormick, G. E., Jr.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 5. Shubin, H., et al.: Antibiotics Annual 1957-1958, New York, N. Y., Medical Encyclopedia, Inc., 1958, p. 679. 6. Isenberg, H., and Karelitz, S.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 7. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy 5:527 (Aug.) 1958. 8. Kaplan, M. A., and Goldin, M.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 9. Truant, J. P.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958.

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Tao Pediatric Drops

For children—flavorful, easy to administer.

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TAO-AC (TAO analgesic, antihistaminic compound)

To eradicate pain and physical discomfort in respiratory disorders.

Supplied: In bottles of 36 capsules.

TAOMID* (TAO with triple sulfas)

For dual control of Gram-positive and Gram-negative infections.

Supplied: Tablets, bottles of 60. Oral Suspension, bottles of 60 cc.

Intramuscular or Intravenous

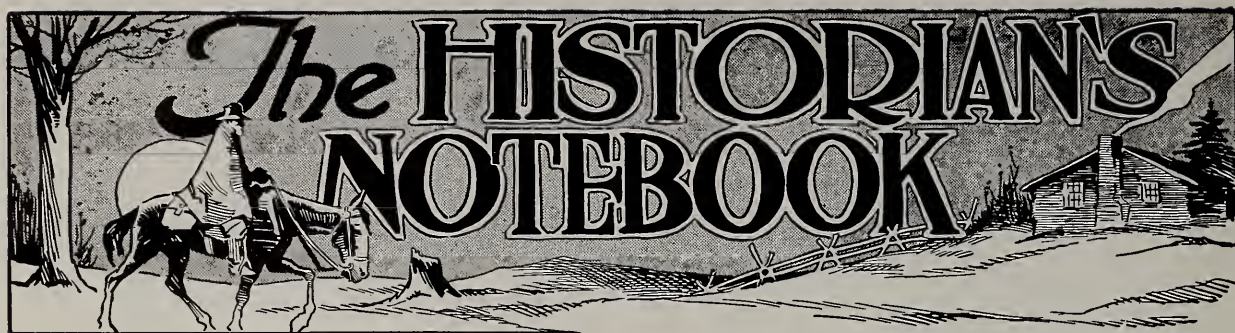
For direct action—in clinical emergencies.

Supplied: In 10 cc. vials.

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Science for the World's Well-Being



Medical Education One Hundred Years Ago— The Introductory Lecture*

GENEVIEVE MILLER, Ph. D.

PART II

(Concluded from December Issue)

IN the competition constantly taking place with quacks and with single dogma practitioners like the homoeopaths and botanic physicians, the orthodox profession was handicapped further by the political climate which extolled ideas of liberty and self-determination. Independence and the rejection of the Old World included the rejection of its intellectual heritage, and some Americans prided themselves in being able to start afresh.

"Our institutions, our climate, our people are peculiar," declared Dr. J. K. Mitchell in 1847, "and peculiarly as a nation are we situated. Ours is a land of progress; one in which men are to reach their ends by new and untried paths. The slow movement of European systems suits us not, and we must look hereafter with more distrust on the men of foreign or of domestic growth, who see in us nothing good, and believe that we can only succeed in policy, war or medicine, by a blind subserviency to orders from abroad."¹³

Nationalism, as recently we saw in Nazi Germany, puffed American plants to treat American diseases. Even indigenous Indian medicine secured a following. "'Indian Root Doctors': a sad monument of the progressive intelligence of the age!" commented Dr. J. Lang Cassels at Western Reserve College in combatting the common notion that Indians knew more about the medicinal action of plants than the whites.¹⁴

Effect of Frontier Life

That frontier life had corroded the professional demeanor of physicians must have been true also,

*Presented at the annual meeting of the Ohio Academy of Medical History, Cincinnati, April 26, 1938.

The Author

● Dr. Miller, Cleveland, is Research Associate in Medical History, The Cleveland Medical Library Association.

else Daniel Drake would not have chastised his colleagues in the following indictment. Criticizing them for the slovenly appearance of their offices he remarked,

"Who can read and think, with method or sound logic, while every thing around him is dirty and disordered? His little stock of furniture displaced, as if a riot had just passed away; his books scattered on chairs, tables, and the greasy medicine-shelves; in his book-cases, volumes of different sets mixed together, some lying flat, and some, like the ideas of their reader, upside down; his skeleton exposed, and joint after joint torn off; his few injected preparations, unvarnished as my narrative, and worm-eaten, as the books of an old doctor; his medicines unlabelled, and thrown into a chaos, as great as a treatise on the *Materia Medica* in the fourteenth century; bundles untied and bottles left uncorked, or stopped with plugs of paper; dead flies in the ointment within his jars, while others are wading through that which has lain so long spread over his counter, that their feet are blistered by its rancidity; his spatulas, foul and rusty; his scales tied with strings and balanced with pieces of paper; his mortar, about as clean as the ancient

Kentucky hominy-block, which, in the same day, contained the food of the family, and the family cow and horse, as it stood convenient to all the parties, on neutral ground, near the door of the cabin; his surgical instruments oxidating and rusting away, like his mind; his study-table, covered with loose papers and medical journals . . . with their covers torn off; his walls overspread with a tapestry of cobwebs; his windows as opaque from dust as the painted glass of an ancient cathedral; his foul candlestick standing all day on his lexicon, and his floor spotted over with the blood of his surgical patients, and his own tobacco-juice!"¹⁵ Thus Daniel Drake described a colleague's office in this period.

Criticism of American Manners

Indeed Charles Dickens was not the only critic of American manners, or rather lack of them, in the 1840's. "Make a voyage upon one of our steam packets," suggested Drake, "and listen to the uproar of the card table, where gentlemen detached from respectable families, in the midst of the aged and reverend, emulate the mingled sounds of all the machinery; watch the dinner table, and see the flaxen-haired youth anticipate the hoary headed sire in the choice of a seat; walk on the guards, where gentlemen's legs continue to rest upon the railings, till you push them off. Seat yourself at the table of a hotel: before you have begun to eat, he on your left will thrust his arm across your breast, that he may abduct some savory plate; you cease for a moment to guard your own, and see a portion of its contents adhering to the coat-sleeves of him who is on your right.

"Walk our streets, and look at the volumes of tobacco smoke, which, like those of a steamer, indicate that a gentleman is about to turn the corner. You meet him. Does he condescend to raise his hat? He does not even think of it. Do you stop to converse with him? He 'keeps up the steam,' and the smoke of his furnace polluted by his breath, draws tears from your eyes, without his intending or giving offence. . . . Visit a lecture room, and what do you see? A salivary infusion of tobacco, drivelling from the corners of a student's mouth, on the skirts of the gentleman before him; while his own is receiving an impress from the dirty boots of the gentleman behind him, as they quietly rest on the back of the seat."¹⁶

Physicians were exhorted to be gentlemen, to be urbane and refined, for their own sake as well as the influence which they exerted on their patients and the community. No other social

group except the very rich had more influence upon American manners.¹⁷

As we all know, in this atmosphere of uncertainty, of lack of public confidence and respect, the instinct for betterment led to an attempt to improve medical education, and it was just during these years that the American Medical Association was organized primarily for this purpose. In the effort to raise standards, as today, preliminary education took a large share of criticism. Practitioners were urged not to accept as house students those for whom, as a Columbus professor said, "Arithmetic is . . . as inscrutable as conic sections; the earth, to their comprehension, is a *terra incognita*, its geography being as unknown as that of the moon to the philosopher; a noun in grammar has to some no more definite signification than the cabalistic ABRACADABRA; and their orthography, as the printers would say, 'has the appearance of being knocked into *pi*!'"¹⁸

Classroom conduct in medical school also left much to be desired. Students came late to class and left early, and many of them went home several weeks before the session was ended.¹⁹ Even worse for the public, the majority of students went into practice at the end of their first year in medical school, when they were legally eligible, since unenlightened public opinion made it difficult for them to prolong their studies.²⁰ Why, if one were legally qualified, should one not begin immediately to make money?

Desire for Wealth

This desire to become affluent resulted in two other temptations in the Middle West in this period: the constant changing of residence to communities which held greater promise, and the allurements of other more lucrative occupations. "Let not merchandise, nor tavern-keeping, nor office-hunting, divide your affections with her," said Drake, speaking of the medical profession. "Let not the sugar-cane boast of a conquest over her; nor the cotton-plant triumph at her desertion; see that she does not perish by the hemp!"²¹

People frequently excused the poor education by declaring that it was impossible to be educated adequately in the Western wilderness where the population was so sparse, and that even inadequately educated practitioners were better than none at all.²² Some professional men even thought that the economic situation of the United States precluded a long expensive training of medical students which was then being urged by the promoters of the American Medical Association. Such a proposal was regarded as a conspiracy of the wealthy aristocrats to oppress the poor who

(Continued on Page 44)

Investigator

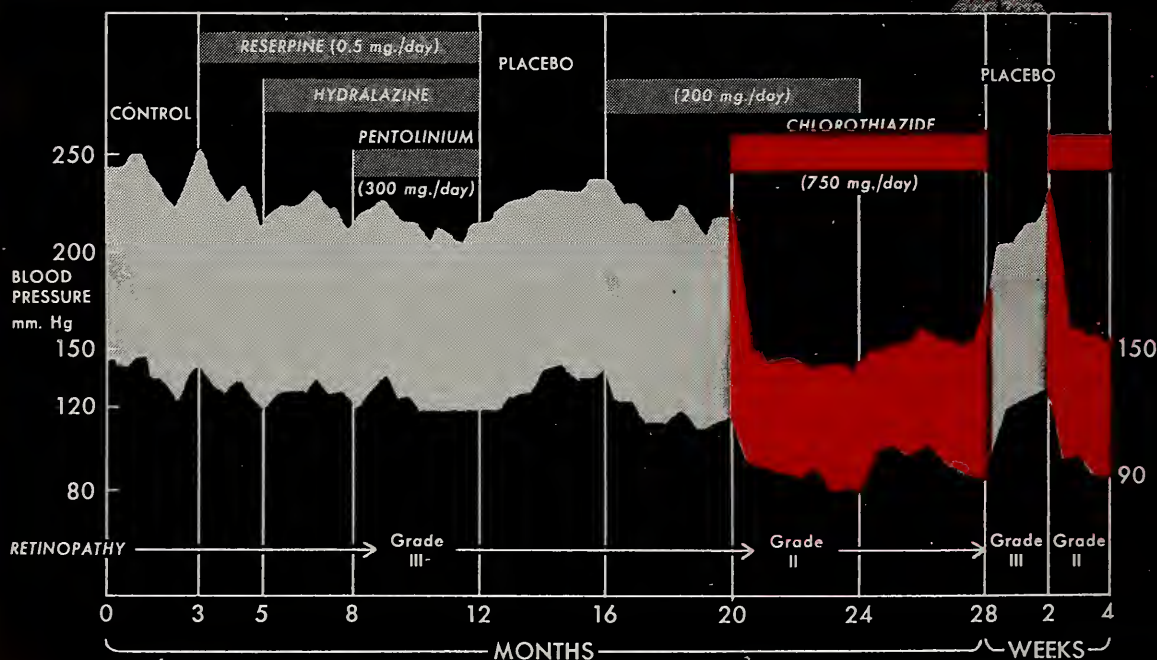
after investigator reports

Wilkins, R. W.: New England J. Med. 257:1026, Nov. 21, 1957.

"Chlorothiazide added to other antihypertensive drugs reduced the blood pressure in 19 of 23 hypertensive patients." "All of 11 hypertension subjects in whom splanchnicectomy had been performed had a striking blood pressure response to oral administration of chlorothiazide." "... it is not hypotensive in normotensive patients with congestive heart failure, in whom it is markedly diuretic; it is hypotensive in both compensated and decompensated hypertensive patients (in the former without congestive heart failure, it is not markedly diuretic, whereas in the latter in congestive heart failure, it is markedly diuretic). ..."

Freis, E. D., Wanko, A., Wilson, I. H. and Parrish, A. E.: J.A.M.A. 166:137, Jan. 11, 1958.

"Chlorothiazide (maintenance dose, 0.5 Gm. twice daily) added to the regimen of 73 ambulatory hypertensive patients who were receiving other antihypertensive drugs as well caused an additional reduction [16%] of blood pressure." "The advantages of chlorothiazide were (1) significant antihypertensive effect in a high percentage of patients, particularly when combined with other agents, (2) absence of significant side effects or toxicity in the dosages used, (3) absence of tolerance (at least thus far), and (4) effectiveness with simple 'rule of thumb' oral dosage schedules."



In "Chlorothiazide: A New Type of Drug for the Treatment of Arterial Hypertension,"

Hollander, W. and Wilkins, R. W.: Boston Med. Quart. 8: 1, September, 1957.

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the effectiveness of

'DIURIL'
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Hypertension

as simple as 1-2-3

1 INITIATE THERAPY WITH 'DIURIL'. 'DIURIL' is given in a dosage range of from 250 mg. twice a day to 500 mg. three times a day.

2 ADJUST DOSAGE OF OTHER AGENTS. The dosage of other antihypertensive medication (reserpine, veratrum, hydralazine, etc.) is adjusted as indicated by patient response. If the patient is established on a ganglionic blocking agent (e.g., 'INVERSINE') this should be continued, but the total daily dose should be immediately reduced by as much as 25 to 50 per cent. This will reduce the serious side effects often observed with ganglionic blockade.

3 ADJUST DOSAGE OF ALL MEDICATION. The patient must be frequently observed and careful adjustment of all agents should be made to determine optimal maintenance dosage.

SUPPLIED: 250 mg. and 500 mg. scored tablets 'DIURIL' (chlorothiazide); bottles of 100 and 1,000.

'DIURIL' is a trade-mark of Merck & Co., Inc.

Smooth, more trouble-free management of hypertension with 'DIURIL'

could not afford to pay for such training. It was anti-republican.

"Exact from our physicians the intellectual culture, and rear in this land the high standard of medical acquirements which are so noble and fascinating in some of the schools of Europe, and quackery will reign almost universal from one end of the continent to the other," declared Martyn Paine of New York, in defending the contemporary status of the American medical profession. "Is not the whole multitude, whether rich or poor, pressing forward either for greater wealth, or for the pittance of their daily bread? Nay, more, do not all our Medical Colleges hold out the temptation of moderate fees, and give, in their annual announcements, a conspicuous place to the humble charges for the necessities of life?"

"And who does not see the inconsistency that would hold in one hand professions of cheapness to allure the student through our present system of medical discipline, and threaten with the other augmented fees and an impossible exaction upon time? The same principle runs through all our primary schools, our academic, collegiate, legal, clerical and political institutions. Cheapness of education, and a corresponding adaptation of time, are found indispensable to the general condition of society."²³

These were the principal problems which confronted the medical profession a hundred years ago as revealed in the introductory lectures: the lack of basic scientific knowledge that could be applied effectively to human ills which resulted in the lack of public confidence, and the strains which a still unstabilized socio-economic environment imposed upon the education, demeanor, and fraternal relationships of physicians.

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17. *Ibid.*, p. 20.
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19. Caldwell, *op. cit.*, p. 23; Drake, *An introductory lecture*, p. 8.
20. *Ibid.*, p. 9.
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22. "As to classical learning, that has long since been laid on the shelf, as unimportant, or useless." Thomas D. Mitchell, *Hints on the connexion of labour with study, as a preventive of diseases peculiar to students*. Cincinnati, 1832, p. 46.
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The Use of Nicotine As a Vermifuge

It would appear that the use of tobacco as a vermifuge was originally a therapeutic accident. In treating a sailor with an abdominal wound, Surgeon Turner (1762) procured a stool by means of fumes of tobacco injected through a tube. During the use of these clysters, several dead worms of the teretes kind came away with the stools. Noting this, Turner concluded that this might be a valuable treatment for worms, and soon after tried it on a man who had been troubled with worms for years. The treatment was applied twice a day, and produced a prodigious number of ascarides.

The worms against which tobacco has been employed include round-worms, tape-worms, thread-worms, and pinworms; and the tobacco was administered by mouth (Cunningham, 1836), as a cataplasm as an adjunct to oral administration (Sigmond, 1838b), but more generally in form of an enema of tobacco infusion. This latter procedure not infrequently resulted in severe or fatal tobacco poisoning, and many cases have been reported in the literature (Tavignot, 1840, 1841; Bertini, 1846; J. B. Wilkinson, 1889; Bleasdale, 1906; Lancet 2: 765, 1894; Ehrnrooth, 1912; Garvin, 1913; Detis, 1937; Willis, 1937; among others).

It is noteworthy that in virtually all of these cases the use of tobacco or tobacco enema as a vermifuge apparently followed lay advice, and the appearance of such cases well into the 20th Century indicates that tobacco still maintains its popularity—and peril—in folk-medicine.—H. Silvette, Ph. D., P. S. Larson, Ph. D., and H. B. Haag, M. D., Richmond, Va.: *Virginia M. Monthly*, 85:472, September, 1958.

Song in the Night: The Story of Dr. and Mrs. Thomas E. Mangum, by L. Alline Swann. (\$1.00, Beacon Hill Press, Kansas City 3, Mo.) It is an attempt, on the part of the author, to portray a vision of the service which two people have given, many years ago. It is a condensation of a larger volume in which the author has endeavored to give a complete picture of the life and work of this doctor and his wife, with special emphasis on the time and energy that they devoted to the Samaritan Hospital School of Nursing. When the history of Nazarenism in the Northwest is written among the key figures will be these people, the founders of the Samaritan Hospital and School of Nursing and ambassadors of world-wide evangelism and medical missions.

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CHARLES S. NELSON,
Managing Editor — Bus. Mgr.

R. GORDON MOORE,
Asst. Managing Editor

A Symposium* Prevention and Treatment of Abortions

Introduction by ARTHUR G. KING, M.D.

WE are told in the first chapter of Genesis that after the good Lord created man and woman in His own image, He directed them to "Be fruitful and multiply." Unfortunately, just as the "Herbs yielding seeds and the fruit tree" do not always bear fruit after its kind, as the good Lord ordained for them to do, so the human reproductive mechanism has its failures. We are coming to realize that while there are numerous factors involved, there is also a pattern. Couples without demonstrable anatomical or physiologic defects can all be placed somewhere along a line representing fertility. At one end is absolute sterility; further along this spectrum is relative sterility or one-child sterility. Still further we find repeated abortion, then occasional abortion, then premature labors, then term pregnancies with stillbirths, and finally untrammelled fecundity.

Today we are restricting ourselves to the prevention of abortion and the medical treatment of it, should it occur.

The importance of the subject lies in the frequency with which the practicing physician meets it. Out of every 100 pregnancies, five according to some authors, 15 according to others, terminate during the first 14 weeks. I believe the higher figure is correct, because there are a lot of so-called missed abortions.

What do we mean by threatened abortion, incomplete abortion, missed abortion, and repeated

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abortion? I can't resist putting in an appeal to abandon the horrible term "habitual abortion" in favor of "repeated abortion." We have habitual drunkards, and habitual criminals, and habitual illegitimate pregnancies, but when we apply the term "habitual" to abortion we are not only insulting the women, but are taking the position that repeated abortion is purely psychological, and the women should be sent to a psychiatrist like habitual drunkards. Not even the most rabid psychosomatic psychiatrist will accept this responsibility.

Three of our colleagues are going to discuss the

*Presented before the Section on Obstetrics and Gynecology April 15, 1958, at the Annual Meeting of the Ohio State Medical Association in Cincinnati, under the chairmanship of Dr. H. Thomas Atkins of Hamilton.

problem for us, and each has his own phase to take up, so that there will be no repetition. Each has his own ideas that do not necessarily conform to the opinions of the others, or to mine, or to many of you in your practice. But discussion of differences of opinion is what makes for the advancement of knowledge.

Keith B. Brandeberry, M. D.:

Missed and Incomplete Abortion

I would like to discuss two subjects: missed abortions and incomplete abortions. In missed abortion the embryo dies, but is retained within the uterus for weeks or months before being expelled. Generally its death occurs quietly before the tenth or twelfth week without any threatening symptoms of abortion in the form of hemorrhage or uterine contractions. Sometimes the subjective and some of the objective signs of pregnancy, such as morning sickness, distention and frequency, disappear and the uterus remains the same size. Menstruation continues to be suppressed although occasionally there is a slight brownish discharge. The diagnosis of this form of abortion may by no means be easy.

There is usually very little if any difficulty in recognizing the existence of the pregnancy but there may be considerable difficulty in deciding if the ovum is alive or dead. Experience shows that time has been the only thing that has been dependable in making the diagnosis. If the ovum is alive, the uterus increases in size while if it is dead the uterus remains unaltered or at times may diminish in bulk. The various pregnancy tests in the early stages of missed abortion may continue to be positive. Theoretically, these should revert to negative but many times the chorionic villi remain alive for a considerable length of time. Likewise, the pregnanediol excretion in urine may not disappear for some time.

Diagnosis and Handling

Frequently in these cases it may be the doctor who first suspects that something is not quite right with the pregnancy. On the other hand, however, the patient may suspect that something is wrong when she fails to fill out her maternity dresses as she expected to do. As indicated, the best method of making the diagnosis is by repeated pelvic examinations over a period of time and failure to denote enlargement of the uterus.

The hardest part of the management of these cases is the patient and her family who feel, without question, that something should be done to remove the nonviable products of conception from the uterus. Usually a thorough discussion of the

problem with the patient will suffice. However, at times there is considerable pressure to do something. One must be constantly on guard not to rush unwisely into a surgical procedure because of pressure from the family. If both the physician and the patient maintain patience, time will usually correct the problem and the products of conception will be expelled. At this time the handling then becomes similar to an incomplete abortion, which I will discuss at length later. We know full well that in cases of missed abortion we must be on guard for bleeding due to hypofibrinogenemia.

If for some reason the physician feels that interruption of the pregnancy must be carried out, there are two methods of approach. The first and probably simplest is hormone therapy. This I have had very little experience with and what experience I have had has not been satisfactory. In the British medical literature one finds many references to this medical therapy which is described as follows: The giving of stilbestrol, 5 mg. at three hour intervals for three days. This is followed by an enema and pituitary extract given by the intravenous route. According to the same literature this is usually a successful method of terminating the missed abortion. The other method of termination is surgical. This of course must be done in the operating room under proper anesthetic and sterile technique by dilating the cervix and evacuating the products of conception. Again it should be emphasized that adequate methods must be instituted to control hemorrhage. In our practice we see an average of seven or eight missed abortions per year so it is not nearly the problem that incomplete abortions is.

Incomplete Abortion

I should like, then, to turn to the matter of incomplete abortions. This is a very common problem, and surprisingly little is written in the literature about it. By definition, incomplete abortion implies the retention within the uterus of a part of the products of conception. Commonly it is a portion of the decidua basalis containing numerous chorionic villi. Later in pregnancy, after the formation of the placenta, portions of the membranes and placenta or even the entire placenta may be retained. In theory the diagnosis should easily be confirmed. In practice, however, it is sometimes quite difficult to tell whether an abortion is complete or incomplete. The symptoms of an incomplete abortion are well known. Almost invariably the patient will give the history of missing one or more periods, then starting with lower abdominal cramps and hemorrhage. Upon examination one finds the cervix partially dilated

and frequently placental tissue protruding through the cervix.

Treatment

It is, then, the treatment, of incomplete abortion that we are most concerned with. It is here we find wide variance of opinion as to the proper treatment. Our thinking about incomplete abortions has by necessity changed during the past few years. It is my opinion that every incomplete abortion should have a prompt dilatation and curettage (D. and C.) This is at variance with the opinion of many others. The treatment of an incomplete abortion must have several objectives in mind. First of all it must be safe, quick, comfortable and reasonably inexpensive for the patient. It should be aimed at returning her to normal activities as soon as possible. Treatment by necessity must be aimed at stopping the hemorrhage and replacing blood loss adequately. It must also stop any infection that is already present and prevent postabortal infection. It should also give us as much information as possible as to the cause of abortion. Upon this basis, I believe that every patient should have a prompt D. and C. upon making the diagnosis of incomplete abortion.

We see about 130 incomplete abortions per year. A review of the past 500 incomplete abortions that we have seen by necessity, goes back about four years in our practice. Of these 500 incomplete abortions approximately 40 per cent had a D. and C. performed in the office. The other 60 per cent have been taken to the operating room for this procedure.

Office Curettage

I should like to say just a few words about an office dilatation and curettage. I should explain that our offices are on the first floor of a general hospital and these patients may well be cleaned out in our office and then admitted to the hospital for 24 hours of observation before they are allowed to go home. As you know, it is the dilatation of the cervix that is painful. The actual curetting of the uterus is relatively pain-free. We have found that if the cervix is dilated enough to introduce the sponge stick and/or the large curet in the office that we can clean out the products of conception safely and comfortably with no anesthesia. The advantages of this are obvious. It is quick, it avoids an anesthetic and especially at night it avoids calling out an operating room crew and anesthetists. Economy-wise it is a saving of \$30 to \$40 to the patient. We keep a sterile curet and sponge stick handy in the office at all times. The only preparation we do is swabbing the vagina out with Ceepryn® solution before we evacuate the products of con-

ception. We have found this to be a safe and effective procedure.

The other 60 per cent were taken to the operating room where usually under Sodium Pentothal® anesthesia a routine D. and C. is carried out. Generally speaking no packing is inserted. We have proceeded on the belief that a clean uterus does not bleed. If there is evidence of infection the patient is placed on routine antibiotic therapy. Of these 500 patients only three showed postoperative morbidity. There was no mortality. The average length of stay in the hospital was 24 hours—all patients are kept at least 12 hours. Forty-five of these patients or 9 per cent of the total required blood transfusion. One patient received the total of six units of blood. Twenty of these patients were septic on admission.

I have no quarrel with those who believe that the incomplete abortion should be treated by the so-called conservative method, that is, by bedrest, frequent blood transfusions, oxytocics and waiting. I do, however, believe that prompt evacuation of the uterus is a sounder, safer and more logical approach than the above. I believe furthermore that it offers several other advantages. By dilatation and curettage one may well find the cause or precipitating factor of the abortion. Congenital defects, malpositions, or submucous fibroids may be noted.

In closing, then, I should like to make two points. First, every incomplete abortion should be terminated by dilatation and curettage as the method of choice. Second, approximately 40 per cent of abortions can safely and comfortably be evacuated without anesthesia as an office procedure.

Albert Hirsheimer, M. D.:

Threatened Abortion

We should start with a definition of threatened abortion. The terms we use are partly descriptive of symptoms, partly of physical events. There is no universal agreement as to when in pregnancy abortion leaves off and labor begins, but 20 to 22 weeks seems a sensible dividing line. The following always suggest imminent termination of a pregnancy:

Vaginal bleeding

Uterine contractions when excessive or painful

Cervical dilatation

Escape of amniotic fluid.

There are no statistics which clearly indicate how often threatened abortion occurs. It must be considerably in excess of the 5 to 15 per cent rate given for actual abortion.

Let us briefly consider the causes.

Bleeding from within the early pregnant uterus

most commonly arises from the decidua. The erosive potential of the trophoblast may get out of control. Vessels may rupture from excessive uterine contractions. The small decidual vessels may be fragile, or there can be a fault in any of the elements of blood clotting. As you know, there is always some bleeding accompanying implantation. There may be enough to escape externally as the "placental sign" at the time of the first or second missed period. The clinical decision whether to consider bleeding physiological or pathological depends largely on the observer's interpretation of degree. More than slight early menstrual or show-like spotting must be given serious consideration. The prolonged escape of dark red and brown effluvia is ominous, suggesting fetal death.

Decidual hemorrhage may be primary from any of these states of the decidua. It may be secondary to fetal death. The defect that eventuates in decidual hemorrhage is much of the time intrinsic to the particular pregnancy. There may be a maldevelopment of the ovum, either the embryo or the trophoblast-placenta apparatus. This may be due to an unfavorable environment, but seems more likely from germ-plasm defect. There may be a faulty implantation site, a poor seed-bed, as when implantation occurs in the lower uterine segment or there has been a poorly developed endometrium because of previous damage or endocrine deficiency. These are usually academic considerations. There is usually no chance to detect the basic pathology unless the abortion is completed sufficiently intact to give an answer on examination. It must be remembered that placenta previa and premature separation probably occurs as often in the first as the second half of pregnancy.

The disturbed physiology that leads to excessive uterine contractions is harder to understand than the cellular changes associated with bleeding. It is clinically obvious that there are irritable, hypertonic, overactive uteri. Rarely is the cause apparent, as in the diminished growth potential of a double uterus or in fixed retroversions. Most of the time we are dealing with an anatomically normal organ and speculating blindly as to the humoral, autonomic nervous, or psychic influences that have gone wrong.

There are instances where cervical dilatation occurs with preceeding abnormal contractions. The defect is in the cervix, usually the result of obstetric or surgical trauma.

Rupture of the membranes is an understandable sequel to cervical dilatation, yet there remain instances when it occurs in a quiet uterus with a

closed cervix, and developmental or inflammatory defects of the amnion must be presumed.

Treatment

The ends sought in treating threatened abortion are simple: Arrest the bleeding, stop the uterine contractions and cervical dilatation. The therapeutic routes we take, however, are not always direct and specific. We can, at least, keep the end in mind, and try to use logical, practical measures. In the first place, in a progressive abortion there will be a point of no return where the vitality of the conceptus has been destroyed, or the dilatation gone too far. Nor, to begin with, can it be told whether the pregnancy is normal, living, or dead.

There are general measures on which most of us will agree. The first of these is bed rest. The question is how long should it be? I would suggest as a practical rule the 24 hours past the last bleeding or cramping should suffice. What of the patient who has persistent symptoms over several days? The law of diminishing returns sets in rather quickly for bed rest, and favorable results are not directly proportional to its duration. The patient who fails to show fairly rapid and progressive improvement at rest is not likely to profit by prolongation of it. Another important rest factor is rest from coitus. The mechanical and neuro-emotional effects cannot but be risky. It is probable that psychic rest, peace of mind, is of equal or greater importance. Rest in a hospital may be to that end more effective than in the home atmosphere.

It bears repeating that threatened abortion patients should always have an early manual and speculum pelvic examination. If this is not done, inevitable and complete abortion will be given the wrong treatment, as will bleeding from cervical lesions such as erosions, polyps, ectopic decidua, even carcinoma.

Drug Therapy

We now come to consideration of pharmacological agents and to the area of least agreement, where there has been many a slip between laboratory theory and clinical practice, and much ill-founded, confounded, clinical reporting.

Agents that would be useful in treating threatened abortions can be placed in three classes:

First, those designed to improve the vitality of the conceptus.

Next, those designed to arrest bleeding.

Then, those that suppress uterine contractility.

Vitamins

Vitamin E has been proposed as directly affecting the vitality of human pregnancy by analogy

from animal experiments. The place of the tocopherols in human pharmacology continues, after many years, to have insubstantial proof. The patient's general physical state is, of course, influential. This may be more important in repeated abortions, but malnutrition, anemia, deficiency states, and infections should certainly be combatted. Use thyroid if you admit that, except in hypothyroidism, it is empiric and a bit of the old white magic.

If it is hypothesized that the bleeding of threatened abortion can be precipitated or substantially aggravated by disturbances of the clotting mechanism, or capillaries, or both, then agents to counteract these dysfunctions should be used. To this end vitamins C, K, and P have been urged. It seems reasonable to accept the possibility that many patients have an inadequate ascorbic acid intake. It seems an over-simplification to postulate prothrombin deficiency on the present evidence, and to assume an extra need for menadione in patients with adequate digestive and liver function. The relationship of the bioflavonoids that comprise vitamin P to capillary disorders has been expanded from very shaky experimental grounds to a clinical use that must still be considered empiric. As far as I know, there is little information about the use in this condition of the other reputed systemic hemostatic agents, such as adrenochrome.

Now, with the exception of general anesthetics, there are no drugs that have a consistently suppressive effect on uterine activity. Opiates and synthetic narcotics may to some degree temporarily alter the pattern of contractility without arresting it. The usual anti-spasmodic agents such as belladonna and anticholinergic substances have no effect on the uterus comparable to that on other hollow organs.

Progestins

Uterine activity is hormone controlled and should be affected by hormone administration. Estrogen is necessary to the contractility of uterine muscle, but does not stimulate contraction in the same sense as Pitocin.[®] Thus, it is really no paradox that large doses of stilbesterol do not empty the uterus. However, that it should be believed to have the opposite effect requires straining at chemical gnats and swallowing statistically invalid clinical camels. Progesterone quiets the uterus in the laboratory. In the patient it has been more often than not, disappointing. This may be because the viable pregnancy is already producing quite enough progestin, or because, until recently, dosage has been insignificant. It is probable that a minimum daily dose should be between 100 and 200 milligrams. It could turn

out that the use of larger doses, or of long acting progestin like Delalutin,[®] or of the oral progestational steroids Enovid[®] and Norlutin[®] will be more fruitful.

The effect of progestins on the endometrium may not be important by the time abortion threatens. What of the other hormones? Adrenalin is short acting and of mixed effect depending on the proportion of epinephrine and nor-epinephrine. Relaxin hasn't had much reported use in miniature labor. Certainly in its exhibition later, a nice balance must be sought between the quieting and cervix softening effects. There is another, perhaps related, ovarian extract, Lutrexin[®], which remains *sub judice*. Most reports concern its use in dysmenorrhea or premature labor which may or may not, by analogy, apply.

Surgery enters the picture only in treating incompetence of the cervix. There is an increasing number of reported successes in the surgical closure of prematurely dilated cervices.

The greatest obstacle to the acceptance of any of the agents is the failure, in most studies, to have proper controls or to give sufficient consideration to the placebo effect.

This brings us again to the point previously noted when we were talking about rest, that the emotional element is very important. Much of the success of any modality may be due to suggestion. It may be suspected that when antispasmodic mixtures contain phenobarbital, it does the work. It is probable that tranquillizers will prove very useful, as Javert has noted for dimethylane and meprobamate.

In summary, the success of any treatment depends substantially on making the patients comfortable, in giving as much reassurance as can honestly be done, in minimizing tension, anxiety, and conflicts. Chemistry will help, but we may wonder who most needs the ataractic, the patient or the doctor, on one of those days when every time the phone rings it's another of those abortions!

Burdett Wylie, M. D.:

Repeated Abortions

The subject of threatened abortion has been discussed. Some of these threatened abortions will subside, either with or without medical treatment, and carry on to term. In others the pregnancy will be lost, in spite of anything that can be done. This is apparently a basic risk that must be faced by every woman who undertakes a pregnancy. While we never consider an abortion as "normal," certainly in any series of cases a certain percentage of abortions is normal. One

hundred per cent success in reproductive processes may be the ideal objective but it is unrealistic. Nature simply does not work that way. A fair percentage of apparently normal couples is sterile, for which no explanation can be found, and of those women who do conceive at least 10 per cent will abort in spite of anything medical science has thus far been able to accomplish.

These facts, however, should not prevent us from making every effort to beat the odds and make these events as infrequent as possible. As already stated, in any given series we can anticipate about 10 per cent abortions. By the same token, if this group of women undertake a second pregnancy, we can anticipate that 10 per cent of those who aborted the first time will do so again. When the third pregnancy gets under way we can anticipate, on the basis of mathematical odds, that a certain number of women will come up with a third consecutive abortion.

In having three consecutive abortions the patient is no longer a simple aborter but she becomes eligible for a special classification. She is a "repeat aborter," or what is sometimes referred to as an "habitual aborter." Does this prove that she is particularly different from someone who has had only one or two abortions? Is she likely to have any anatomical or other defect that can be demonstrated? Or is it a pure coincidence brought about by the normal abortion expectancy? The chances are that nothing will be found about her that differs from any other woman, except the history of repeated loss of pregnancy.

If we assume a perfectly random distribution of a given percentage of miscarriages, then every pregnant woman would be subject to the same risk, and examination of an adequate series of cases would demonstrate this uniformity. In reality, however, the dice appear to be slightly loaded, so that some women have less than their share of trouble while others have more miscarriages than would be expected on the basis of a purely statistical distribution.

In anticipation of this discussion I went over the obstetrical records of 1000 consecutive cases from my file. They were unselected except that each had been pregnant at least one time. These 1000 women had had 2740 pregnancies, including 358 abortions, an over-all abortion rate of 13 per cent, or one pregnancy out of every seven was lost. Had there been an equal distribution, 31 per cent of the patients would have had at least one miscarriage. Actually the miscarriages were had by only 26 per cent of the group. This is not a great difference but it does indicate that the cards were slightly stacked

against those women who did abort. They had more than their share.

As for second abortions, analysis of the same series shows that there were 829 women with two or more pregnancies. Nineteen of these lost their first two pregnancies. On a completely random distribution there should have been only 12. Similar, but because of a small series, less reliable figures were found for the three consecutive abortion group. This seems to indicate that the occurrence of spontaneous abortions as well as repeated abortions is primarily a matter of chance distribution which is only slightly influenced by individual variation or predisposition.

Anatomical Factors

Among factors which may predispose to repeat abortion one might mention congenital anomalies, such as septate or bicornate uterus; this is undoubtedly a factor at times. It so happened that in my series there were five such cases, who had 10 pregnancies with no abortions at all. Simple retroversion is probably never a cause of abortion but an incarcerated retroversion will eventually cause a miscarriage unless it is corrected, and even the correction, unless done with considerable care, will add to the hazard. The fixed retroversion will tend to recur with second pregnancies and hence may again be the source of trouble. However, it must be pointed out that the mere fact that a woman with retroversion has a miscarriage does not at all establish a cause and effect relationship.

Infantile uterus is probably the cause of trouble at times, particularly in first pregnancies, but since pregnancy tends to correct the condition it is not apt to be a factor in repeated abortions. The incompetent cervix has recently been described and is undoubtedly a factor when present. Success has been reported after its surgical correction. Uterine fibroids which are bulky or which encroach upon the endometrial cavity can, of course, cause trouble. Age, apparently, is an important factor, possibly due to faulty glandular support of the pregnancy, but this is probably not too important in the repeat abortion area.

Psychophysiological Factors

Physical activity is probably not an important factor, although a woman who has previously aborted should be advised to take special care to avoid any strain or exertion during her next pregnancy. Javert believes that sex relations early in pregnancy can cause trouble. I have seen a few instances where there appeared to be a connection.

Within the past year I successfully delivered a patient following a series of nine consecutive early abortions. The patient attributed her success to

the fact that they had abstained from intercourse throughout this pregnancy, an accomplishment achieved by virtue of the fact that her husband had joined Alcoholics Anonymous and hence was willing and able to cooperate in this project. A psychiatrist would probably make much of this case as being an illustration of the value of relief of mental tensions, et cetera, but I believe we are on more firm scientific ground in assuming that it was the absence of physical rather than mental disturbance that carried this pregnancy to term. The low incidence of abortion stated to exist among unwed mothers may in part be due to the fact that there will normally be less opportunity for intercourse here. Certainly freedom from mental tension cannot be offered as an explanation for the low incidence of abortion in this group.

Humoral Factors

The reports which attach significance to deficiencies in hormones and vitamins and the amazing cure rates reportedly brought about by the use of stilbestrol, progesterone, and various prescriptions of C, E, K, P, et cetera, are unconvincing. However, they may have some value which is as yet undemonstrated. In evaluating any treatment it is wise to remember that when a woman has a miscarriage her chances are better than 80 per cent for a normal pregnancy the next time without any treatment. After two consecutive abortions the odds are still better than 60 per cent. This makes critical evaluation of any course of treatment practically impossible for the individual practitioner.

True abortion repeaters (three or more consecutive abortions) are only seen once in about 300 cases. Reliable statistics can be collected only in large clinic series and the therapeutic agent here would still have to improve upon a 15 to 20 per cent chance that the patient would have a normal pregnancy without any treatment. Let me hasten to add that I do use these preparations. It is part of the sympathetic understanding and psychological support which the patient has a right to expect of her doctor. She also has the assurance of knowing that her doctor is giving her the very latest things about which she has probably recently been reading in a popular magazine.

Treatment

The management of abortion repeaters must, of course, include a search for and correction, if possible, of any physical or emotional defect. Prior to the next conception, or as soon thereafter as possible, hormone and vitamin preparations should be started. They may be of some value in addition to their psychological support. Advise

sexual abstinence until at least the fifth month and also the avoidance of long auto trips or other strenuous activity. In the interest of good health and hygiene, search for and make every effort to relieve anxiety and nervous tensions.

Every pregnant woman should be prepared to accept miscarriage or other accident of pregnancy as a possibility. It is just part of the normal risk involved in having a family. Explain to the patient that if, in spite of everything, she should again lose the pregnancy she can always try again. In the series of 1000 cases cited I found only two patients who did not carry at least one pregnancy to term. These were patients who, after two consecutive abortions, did not come back to see me again. They apparently decided to change their luck by going to another doctor. I have no doubt that if they kept trying they also have now had the children that they wanted.

In brief, abortion, even repeated abortion, is a calculated risk that must be accepted by every pregnant woman. The chance of recurrence in all subsequent pregnancies is extremely small and even this hopeful prospect can probably be improved upon by careful supervision. If a woman really wants a family she must just keep trying. If she does, she will have her children.

Current Status of the Hemophilia Problem

Although knowledge of the various factors concerned in coagulation has increased greatly in the past few years, little change has occurred in the treatment of severe classic hemophilia. Today, as it was twenty years ago, the chief therapeutic agent is still whole blood or plasma. The goal in the management of an episode of bleeding is to use enough plasma to keep the concentration of antihemophilic globulin (AHG) high enough to allow hemostasis and healing to take place. Except in an emergency, it is preferable to use fresh, freshly frozen, or freshly lyophilized plasma. . . .

It is generally accepted that AHG is more stable in banked blood than was formerly believed. Therefore, blood banked under modern conditions or plasma is probably acceptable in the treatment of classic hemophilia for several days after it has been drawn. It is best to use fresh whole blood only in those situations in which excessive loss of blood has occurred, or if anemia is present. Special lyophilized preparations of AHG are more expensive than plasma but they have the advantage of indefinite stability and immediate availability regardless of the group of the patient's blood.—William F. Westlin, Jr., M. D., Stephen D. Mills, M. D., and Charles A. Owen, Jr., M. D., Rochester, Minn.: *Minnesota Med.*, 41:705, Oct., 1958.

The Handling of Radioactive Materials

JOSEPH A. QUIGLEY, M. D.

THE Sputniks, Explorers and the late recession have removed radiation and its effects from the limelight at least temporarily and have made it possible for the medical profession to properly evaluate the real problems associated with radiation and to calmly review the progress made to date in successfully coping with them.

What are the problems? What solutions have been developed to these problems? The problems as stated by Dr. George Tievsky in *The Journal of the American Medical Association* are: (1) Genetic, and (2) Somatic.

Genetic Effects

The geneticists are interested in populations—be it fruit flies, mice or humans. Understandably most of this information has been obtained with fruit flies and animals, and the results obtained have been extrapolated for human beings. This may lead them to correct conclusions. More experimental work is needed. This will take time, probably much more time.

At the moment, however, the geneticists are in agreement on many points:

- (1) Irradiation of the gonads produces genetic change.
- (2) Such changes in the genes are almost always undesirable.
- (3) There is no threshold dose genetically.
- (4) Once damage is done, it is irreparable; the damaging effects are therefore cumulative over the years.
- (5) Mutations may not be recognized in the first generation; only in the second and later generations.

I believe that we, as industrial physicians, must today accept those points on which the geneticists are in agreement. We must plan accordingly.

The geneticists are *not* in agreement on the relationship between radiation dose to the gonads and the degree of genetic damage. Until this point is settled, at least, we in industry must strive to keep the dose to the gonads at the lowest level attainable.

Somatic Effects

This deals with the effect of radiation and radioactive materials on the individual from all physical aspects other than genetic. It is concerned with

The Author

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the effects on skin, lung, liver, bone marrow, etc. Radiation has been used in medicine for over 50 years. While we, as physicians, are perhaps less emphatic about our opinions than the geneticists, we do have much more human experience on which to base these opinions. Most of us agree that in adequate doses radiation can cause damage somatically. It may, therefore, produce:

- (1) Skin Burns
- (2) Neoplasms
- (3) Cataracts
- (4) Leukemia and other blood dyscrasias
- (5) Therapeutically, in large doses, it has been used to produce sterility.
- (6) Prolonged exposure to appreciable doses may cause shortening of life.

The National Committee on Radiation Protection has recommended Maximum Permissible Doses for whole body exposures. None of the above conditions have been produced where the dosage was limited to the maximum permissible level.

Over the years these maximum permissible levels have been progressively lowered from 60 R to 30 R, then to 15 R, and within the last year and a half to 5 R per year. It is *most* important to remember that at none of these levels of dosage have any of the foregoing conditions been seen. The maximum permissible dose level has been lowered because experience has shown that the lower level was readily attainable.

The above dosage levels apply to whole body irradiation. We need more information on localized doses, but in this field, too, more information is becoming available. It is recommended, however, that we limit diagnostic exposures to those procedures which are essential.

The handling of radioactive materials which may become airborne and so be introduced into the body is again another problem. Here, too, the National Committee on Radiation Protection has provided us with maximum allowable concentra-

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tions for breathing air. To the present time, at least, these levels appear to be safe levels.

Industrial Medicine has gone through three major phases to date. One is the restorative or therapy stage. In this stage, we as physicians entered the scene only after the workman had been injured or had contracted a definite occupational disease. Second is the stage of early diagnosis, where we attempted to diagnose incipient diseases and remove the man from exposure before he developed a serious debilitating disease. Third, the stage of prevention. Although all three types of industrial medicine are to some degree practiced today, it is the third type which I wish to discuss in some detail.

Good industrial medicine is no longer the province of the industrial physician or nurse with a slight assist from a safety man. Today, good preventive industrial medicine requires a health team. Ideally, this team should function under the direction of a well-trained industrial physician. The team, however, must consist of more than the usual complement of nurses, x-ray technicians and clinical laboratory technicians who were so important in the stage of early diagnosis. Today's team requires these same members, but in addition, it needs the assistance of capable industrial hygienists, safety engineers, chemists and physicists. In the radiation industry—more than in any other—the health team has been developed to the fullest. I believe, however, that the pattern will spread to all industry which attempts to provide a complete preventive health service.

A great many of the "scare" stories which have appeared on radiation stem from a joint report issued by the National Academy of Sciences and the National Research Council in June, 1956. This report was entitled "The Biological Effects of Atomic Radiation." The section on genetic effects has undoubtedly been the most publicized. In the section on pathologic effects, however, the following statement appears: "Despite the existing gaps in our knowledge, it is abundantly clear that radiation is by far the best understood environmental hazard. The increased contamination of the atmosphere with potential carcinogens, the widespread use of many new and powerful drugs in medicine and chemical agents in industry emphasize the need for vigilance over the entire atmosphere. Only with regard to radiation has there been a determination to minimize the risk at any cost."

The record of only two occupational deaths and 44 diagnosable injuries in over 15 years attest to the fact that the hazard had been controlled far better than any new force which was ever intro-

duced into industry in the past. For many years now, upwards of 75,000 people have been exposed to some degree in research, development and production. The hazards, therefore, are well defined and adequate methods of protection not only exist but are available on a practical basis.

What then are the hazards? How do we measure them? What means of protection are available? The hazards are:

- (1) External radiation
- (2) Internal emitters
- (3) Chemical toxicity

(1) External Radiation

Effects

At a meeting such as this it is hardly necessary for us to go into the details of radiation effects. I believe that it is sufficient for us to remember that external radiation may be penetrating or relatively soft radiation. In either case its effect is the result of ionization produced in the tissues which are exposed. We must also remember that the dose decreases as the distance from the source increases.

Method of Measurement

It's in this phase that we are in a favorable position when compared to other industrial hazards. It is very easy to measure not only the amount of radiation in the working environment but to determine reasonably accurately the actual exposure of each individual workman. This can be done by the use of pocket dosimeters and radiation film badges. It is also possible to use area monitoring equipment which can be tied in to an alarm system that will sound an audible warning at a predetermined radiation level.

Protective Measures

To maintain industrial employees at or below the maximum permissible dose for external radiation, certain protective measures must be understood and followed. The intensity of light diminishes as we get farther from its source. The radiation dose likewise diminishes as we get farther from the source of radiation. Distance or space from a radiation source is, therefore, our "number one" protective measure.

The density of air is quite low. By interposing any material of greater density between the source of radiation and the human body, the distance may be reduced. The greater the density of the interposing material, the greater may be the reduction in the safe distance from the source. As you all know, lead is ideal shielding material. Wood, steel, water, and concrete all form excellent shielding materials. Given the intensity of the source,

it is but a simple mathematical problem to determine the thickness of any shielding material which is necessary to create satisfactory working conditions in the vicinity of the source.

(2) Internal Emitters

Effects

Internal emitters for the most part gain entrance to the body through the respiratory tract in the case of soluble compounds and through a combination of the respiratory and digestive tracts in the case of insoluble compounds. In either case they enter the blood stream and will be incorporated in the new cells which are being formed throughout the body. Heavy metals such as uranium and radium will tend to deposit in bone. Other materials such as polonium may deposit in the liver or spleen. The important point about the internal emitters is that they will continue to exert an influence on the tissues surrounding them as long as they remain in the body. We must, therefore, protect against the entrance of internal emitters into the body.

Methods of Measurement

In the case of internal emitters it is possible to measure the amount of specific material present in the breathing air. This can be done simply by the use of a stop watch and a portable air pump wherein we collect the radioactive material on a filter paper. This filter paper can then be placed in standard counting apparatus, and by knowing the amount of material collected, the sampling time and the quantity of air passed through the filter, it is but a matter of simple mathematics to determine the concentration of radioactive material in the air.

In addition to these field measurements, one should also determine the amount of the specific radioactive material which is present in the urine. This is a job for the chemist. In this way we are using the man as a sampler. It is possible to roughly correlate the results so obtained with the results of the air analyses.

Protective Measures

Protective measures against airborne radioactive material should consist primarily of the removal of the material at its source of generation. This requires the application of adequate ventilation at all points where radioactive material may become airborne as a dust, mist or fume. The principles involved in removing nuisance dusts in general apply in this instance. However, because of the comparatively low maximum allowable concentration— $50 \mu\text{g}/\text{M}^3$ of air for uranium—it is usually necessary to make extensive use of

hoods over machines or to carry on operations in a ventilated dry box.

It is important in designing the ventilation equipment to adequately size the ducts so that the material will remain airborne until conveyed to an adequate dust collector. For this reason, and because of the value of the material, it is desirable to design an adequately balanced system, since if dampers are used, the material will be deposited on or near the dampers.

Less desirable as a means of protection is the use of respirators. Although there are many respirators which have been approved by the Bureau of Mines for use in dusty atmospheres, we have found them to be inadequate. There is no question that properly used these respirators would be satisfactory.

Experience, however, has shown us that the average individual will not properly apply a dust respirator, so that a false sense of security may result. We have, therefore, recommended the use of airline respirators. These should be installed from a central air system at sites where such protection is frequently required for maintenance jobs. At sites where less frequent use occurs, portable tanks of breathing air can be used.

Of equal importance with the foregoing protective measures is the training of the operators to do their work in such a manner as to cause the least amount of material to become airborne.

(3) Chemical Toxicity

Certain materials when introduced into the body have a toxic effect—for example, lead, mercury and carbon tetrachloride. It is important to remember that many radioactive materials may also have a toxic effect. Their action in the body from a toxic point of view will be the same as their non-radioactive isotopes.

Conclusion

In conclusion—while the concept of a health team is not entirely new, I believe it is one that will find broader application in the future. The physician alone or a medical department alone, as we know them, is not in a position to make the field tests which are necessary for good control. The industrial hygienist and the safety engineer, working together, can do a great deal to teach each employee better working habits. Protection against external radiation and radioactive materials is expensive. It is, however, not out of proportion with proper protective measures against toxic materials commonly used in industry. I believe that it is not a question of "can an industry afford proper protection?" but rather it is a fact that no industry can afford to be without it.

Hesper-C in Acne

ROBERT J. PEIRCE, M. D., WALLACE H. BUKER, M. D.,
and STANLEY L. BRODY, M. D.

THE treatment of acne calls for a multifaceted regimen based on certain definite tenets, but with each dermatologist having his own preferences and particular twists. This note is to add another suggestion and is intended to be provocative rather than to prove a point.

A group of acne patients that did not do well on our usual course of treatment was given Hesper-C® in addition; they then showed a gratifying change in their response. Hesper-C which contains 100 mg. each of ascorbic acid and hesperidin complex per capsule, was used first in an effort to modify the distortion and dysfunction of the smaller blood vessels in a case of acne rosacea. During the period of administration, the acneform lesions improved greatly. A few acne patients who had been under treatment for some months with only slight improvement then were given Hesper-C in addition to their other medications. As results in them, too, appeared to be good, all patients whose progress had been disappointing were included.

A total of 71 patients were given the ascorbic acid-hesperidin combination; however, only those who continued on the drug for more than one month and who returned to the office regularly for appointments are included. There are 30 acne patients in the series who received Hesper-C, four capsules daily, for periods of one to six months, four of whom had cystic acne. The severity of disease was graded moderate in one, average in 18, and severe in 11. The duration of acne ranged from one month to 25 years, and the previous period of treatment ranged from one month to 24 months. Treatment consisted of staphylococcus toxoid, Lotio Alba, low fat diet, special acne-aid soaps, ultraviolet, hormones, and in some, vitamin A and antibiotics.

Overall results were considered good in 29 and fair in one case of cystic acne.

A Representative Case History

The patient, a 20 year old white male, presented himself to us with acne of the face with moderate pustules and pitting for a duration of six years. The only history of note was that the patient mentioned that excessive use of chocolate, nuts, cokes and fried foods would cause an aggravation of facial dermatitis.

The initial treatment consisted of a low fat-carbohydrate diet, Lotio Alba, Sulfur Resorcin soap, mild exfoliative doses of ultraviolet and staphylococcus toxoid to help control the secondary infection. This patient followed this regime with fair regularity for 11 months with only fair improvement. The patient was then started

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on Hesper-C two capsules, four times daily for one week and then one capsule, four times a day thereafter. In four weeks, there was definite improvement which continued to exist as long as the patient was followed.

Summary and Conclusions

Twenty-nine of 30 cases not responding well to acne therapy showed a definite improvement when Hesper-C was added. It is hoped that a large clinic will see fit to run a placebo-controlled study to evaluate more critically the effects of hesperidin and ascorbic acid in the treatment of acne.

Functional Studies of the Liver In Clinical Practice

It is necessary for the clinician to be selective in his choice of functional studies of the liver. His objective is to employ as few simple and inexpensive tests as possible to obtain desired information for diagnosis or treatment. . . .

Acute Viral Hepatitis.—A combination of history, physical examination, a flocculation test, and serum transaminases usually permits a clinical diagnosis of viral hepatitis. The diagnosis is more difficult with the anicteric and cholangiolar forms of this disease. Having decided that a patient has this disease, the physician is then interested in determining response to therapy.

During the icteric phase, serial studies of cephalin-cholesterol flocculation test, serum transaminases, and serum bilirubin provide adequate information. Bromsulphalein excretion provides the best test for following the clinical course of the patient after icterus has disappeared.—Carroll M. Leevy, M. D., Jersey City, N. J.: *New York State J. Med.*, 58: 3803, December 1, 1958.

Tomography of the Sternoclavicular Joint

EDGAR C. BAKER, M.D.

PRIOR to the last three years roentgen examination of the sternoclavicular area was, for me, a waste of time and effort. None of the standard projections or any projection that I could devise gave me sufficient information to be worth the time and effort involved. The fingers of my Orthopedic friends were far more accurate than the x-ray examination.

The group from Harper Hospital in Detroit had a display of films of the sternoclavicular joints at an American Medical Association convention about three years ago. These films showed this area with marked clarity. Following this display we started to make routine tomographic examination of this area at any time suspicion of trauma or of pathology was directed to this point.

With this method we are now sure that the roentgen examination does offer detailed information which is more accurate than the finger tips of the surgeons both in cases of pathology and cases of trauma. Very early in the use of this examination we found that dislocations of the sternum and of the clavicle are not infrequently associated with fracture. Clear-cut pathology in this area has been picked up and demonstrated accurately.

Tomography is an old method, starting back in the late 1920's. The method has been used, largely, in chest diagnosis and probably too infrequently for diagnosis of bone conditions in different parts of the body. The recent addition of the so-called book of films in which some five to seven films can be exposed at one time has increased the usefulness of the method considerably.

As you know, the tube is moved in one direction over the patient and the film is moved in another direction under the patient about a fixed fulcrum which is essentially at the level of the pathologic condition or of the area to be examined. The patient can be examined in either the prone or the supine positions. From the standpoint of the patient it is easier to examine in the supine position. From the standpoint of the examination it is more accurate to examine in the prone position. The part to be examined is closer to the film and the position tends to accentuate any possible dislocation.

The resulting film shows marked clouding of the area outside of the plane of the fulcrum. Where there are numerous overlapping tissues the plane of the fulcrum can be brought out more

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clearly than usually seen by regular roentgen examination.

Summary

In summary: The examination of the sternoclavicular joint by roentgen methods should include tomography.

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEPFEL, M.D.
Columbus, Ohio, Chairman

Following is the summary of a case which was discussed before the Franklin County Pelvic Cancer Delay Committee on October 15, 1958.

Case No. 64: Patient first seen 48 months ago with history of vaginal spotting on three occasions since the previous December. In surgical specimen very poorly differentiated adenocarcinoma of endometrium was found. Carcinoma was limited to the inner aspect of the uterus with penetration of the myometrium for 2 to 3 cm. This patient was extremely apprehensive. Family requested that diagnosis not be given to her.

Three years later, in September, the patient developed left costovertebral angle pain. X-Rays revealed left hydronephrosis. Patient hospitalized. Laparotomy showed blockage of left ureter by massive tumor which extended into iliac vessels but not the right pelvis. Left nephrectomy carried out. Patient rehospitalized 13 months later. X-Rays reveal right hydronephrosis. Pelvic examination indicates a frozen pelvis.

Comments

DR. POMEROY: Preliminary dilatation and curettage would have revealed presence of carcinoma.

DR. HOLLENBECK: We feel that the best plan of attack on endometrial carcinoma is combined preoperative irradiation followed in six weeks by total hysterectomy and bilateral salpingo-oophorectomy.

DR. EZELL: This radiation is best given in form of intracavitary irradiation plus colpostat and tandem to prevent recurrence in the vaginal vault.

DR. HOLZAEPFEL: When a diagnosis of carcinoma is made on a surgical specimen, follow-up irradiation is generally indicated. A small colpostat is placed across the vault and followed with external x-ray. In this instance follow-up x-ray was not given due to patient and patient's family. It points up the necessity of sometimes having to alarm a patient with a diagnosis in order to carry out complete therapy.

Presented at a General Session at the Annual Meeting of the Ohio State Medical Association in Cincinnati, April 15-17, 1958.

Brain Tumor

A Case Report on Preventable Blindness

WILLIAM H. HAVENER, M. D.

A BLIND EYE is a serious loss to both patient and community. Awareness of the preventable nature of a significant portion of this blindness should help in reducing the incidence of such tragedies. The representative cases to be presented here are selected to emphasize relatively common causes of blindness which can in many instances be averted by proper, timely care.

Case Report

This 46 year old white man first had right frontal and orbital headaches one and a half years ago. These headaches were moderately severe, frequent, usually of about 20 minutes duration, and not associated with other symptoms. During this time he repeatedly sought medical care and was found not to have sinus infection, hypertension, or glaucoma. For eight months he recognized gradually progressive visual loss in right eye which was treated with nicotinic acid without improvement. He was finally directed to a neurosurgeon by his neighbor!

Definite diagnosis of pituitary tumor was made through radiologic demonstration of enlargement of the sella turcica. Even at this advanced stage, only a few positive physical findings were present; nevertheless, these few were characteristic. Visual acuity was O. D. counts fingers; O. S. 20/30. The visual field showed classic bitemporal hemianopia, with marked loss of the right temporal field and early loss temporally O. S. No other abnormal neurologic findings were present. There was no visible papilledema or optic atrophy.

Radiation therapy of the pituitary arrested further progression of visual field loss and eliminated the headaches. The lost visual field was not restored, and the right vision remains only counting fingers.

Discussion

Since the visual pathways are extensive, running from the front to the extreme posterior pole of the brain, they are frequently damaged by intracranial disease. Reduced vision may be one of the early definite signs of intracranial pathology. *Measurement of visual acuity* by a Snellen-type wall chart is the most rewarding single test of eye function, is so easily done that an inexperienced assistant can rapidly be taught to record acuity accurately, and yet is probably one of the most neglected parts of the physical examination.

An even more delicate measurement of the integrity of vision is *perimetry*. Lesions throughout the visual pathways, whether in optic nerve, chiasm, tract, radiation, or cortex produce definite localizing visual field defects. Careful perimetry is mandatory in all cases of unexplained visual loss. Confrontation fields have the advantage of being easily done clinically and are very valuable if positive; however, the physician must realize that the more delicate methods of perimetry with small test objects will detect much earlier lesions than will the gross confrontation field. Perimetry has the great advantage of being painless and atrau-

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matic, in contrast to many other neurosurgical diagnostic methods.

Visual fields should be included in the complete examination of any patient suspected of central nervous system disease. Unexplained recent headaches indicate perimetric examination. Malin-gering and hysteria can be demonstrated very nicely by their typical bizarre field characteristics.

In addition to the perimetric and visual findings already discussed, papilledema or optic atrophy are serious signs readily observed through examination of the optic nerve with an ophthalmoscope. The importance of these neurologic findings is that they immediately indicate the probability of serious disease and the need for thorough examination. The experienced physician is acutely aware of the problem of differentiating tension headaches and multiple vague everyday complaints from the uncommon serious diseases, and knows the differentiation is aided by seeking neurologic findings such as those just described.

The average patient is unaware that ocular symptoms of serious medical, neurological, or ophthalmological diseases may closely simulate the symptoms of refractive error. All patients with ocular complaints deserve skilled medical evaluation. Study of case histories of preventable blindness all too often repeats the pattern of early symptoms disregarded by the patient, unrecognized by the nonmedical optometrist, and occasionally misinterpreted by a hurried physician. Although the United States has now the lowest incidence of blindness among major nations, there are still 17,000 legally blind men, women, and children in Ohio. Application of presently existing medical knowledge could have prevented much of this blindness, and our best efforts must be directed towards this end.

Concurrent Administration of TACE and Ergonovine

R. O. NULSEN, M. D.

IN NON-NURSING mothers two etiologically related conditions—painful breast engorgement and uterine atony—frequently disturb the postpartum period. Breast discomfort is caused when distended ducts are not emptied by the infant; and failure of the infant to nurse is thought to interfere with the development and maintenance of uterine tone, a process normally mediated through the pituitary. The first of these conditions, painful breast engorgement, is successfully treated with estrogens; ergot preparations enjoy wide use as uterine stimulants.

The successful use of TACE®* in 100 cases of postpartum breast engorgement was first described by the author in 1953;¹ later in the same year he reported equally effective results in an additional 802 cases.² Three other groups of investigators published confirmatory data based on a total of 3,261 cases.³⁻⁵ The effective dose of TACE was 48 mg. daily for seven days.

In all of these studies, TACE was found to be superior to other estrogens because its use was only rarely followed by secondary breast engorgement or withdrawal bleeding. These advantages stem from the unique property of TACE to be stored in the body fat following oral administration.⁶⁻⁷ At the end of a course of therapy there is a gradual decrease in estrogenic activity as TACE is slowly liberated from the fat depots. This is in contrast to short-acting estrogens whose effects cease shortly after they are discontinued. The sudden fall in estrogen levels that occurs is believed to be responsible for the higher incidence of secondary engorgement and withdrawal bleeding that follows their use.

Simplified Dosage

In 1955 Eichner and his associates⁵ reported that a seven-day course of TACE was not necessarily required for the successful control of painful breast engorgement. They found that the total dose, given within the first day or two, produced satisfactory results provided the treatment was started promptly after delivery.

This regimen, although effective, was somewhat inconvenient because the special solvent required for TACE at that time necessitated the use of a rather large, soft gelatin capsule for each 12 mg. of medication. Recently, through the use of a special base it has become possible to provide

*TACE is the trademark of The Wm. S. Merrell Company, Cincinnati 15, Ohio, for its brand of chlorotrianisene.

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25 mg. of TACE in a relatively small, easy-to-take, hard gelatin capsule. This permits a full course of TACE to be given conveniently in the first two postpartum days.

Present Study

In the first part of the present study, a series of 34 patients received 50 mg. of TACE three times daily for two days starting immediately after delivery. Concurrently, one tablet of methylergonovine maleate (0.2 mg.) was given four times daily during the first two days following delivery to secure firm uterine contractions.

The results were most satisfactory. An excellent to good response occurred in 31 patients; fair results were obtained in one patient; and there were two failures. Secondary engorgement occurred in only one patient. The uterus maintained its tone and withdrawal bleeding did not occur. These results, so similar to those reported in previous studies,¹⁻⁵ leave little doubt that accelerated therapy with the new 25 mg. TACE capsules is just as effective as the original seven-day course.

In the second part of the study, a capsule containing 25 mg. of TACE plus 0.1 mg. of ergonovine maleate was studied. The objective was to determine whether this combination could control postpartum breast engorgement and, at the same time, prevent uterine atony without additional, separate ergonovine. Ninety-two patients were studied. Each received two of the combination capsules three times daily during the first two days following delivery. An alternate dosage schedule of two capsules within the first eight hours after delivery followed by two capsules every six hours may also be used if it fits into the hospital schedule.

The results were highly gratifying. Breast engorgement did not occur at all in 72 patients, was minimal in 10, and moderate in an additional three. In four other patients the immediate response was good but engorgement occurred later,

usually on the third or fourth day. In two cases it lasted for 24 hours and in the other two it subsided in 10 hours. Little or no benefit was noted in the remaining three patients. Uterine tone was equally as good as that observed in the patients previously treated with TACE and methyl-ergonovine maleate separately. Lochia was normal and again there was no withdrawal bleeding.

An additional 43 patients received two of the combination capsules three times a day for three days beginning immediately after delivery. The results were almost identical to those obtained with the two-day dose.

Discussion

The new combination of TACE and ergonovine maleate offers a convenient and economical means to accomplish two important postpartum objectives. The ergonovine prevents uterine atony and postpartum bleeding and eliminates the need for separate use of this drug. TACE through its fat storage action effectively wards off postpartum breast engorgement and prevents secondary filling. Absence of withdrawal bleeding, an important feature, is another advantage resulting from the unique fat-storage property.

Administration of the total dose of 300 mg. of TACE in just two days instead of the usual seven makes it possible to complete a course of therapy before the patient leaves the hospital. The fat-storage property of TACE and its gradual release allows it to be given in a dosage schedule that corresponds with that of the ergot preparation. Equal effectiveness of a three-day schedule allows an increase in ergonovine dosage when required. The slight additional amount of TACE given in a three-day course is well tolerated and does not lead to adverse effects.

Summary and Conclusions

1. Postpartum mammary engorgement was just as well controlled by TACE in a preliminary series of 34 patients given 50 mg. three times daily for two days starting immediately after delivery as it has been following the established dosage schedule of 48 mg. daily for seven days.

2. The effectiveness of this new dosage schedule made possible utilization of combined TACE and ergonovine administration, since the total dose of TACE could be given within the two or three-day period during which the usual ergot preparation may be expected to produce firm uterine contraction without likelihood of after-pain. Such combined therapy has the advantage of permitting the patient to complete treatment before leaving the hospital.

3. Two dosage schedules for combined TACE and ergonovine therapy were explored. One

group of 92 patients received 2 capsules three times daily for two days and the other group of 43 patients, 2 capsules three times daily for three days. Relief of breast engorgement in both groups was highly gratifying. In only four cases was there recurrence of breast engorgement, and withdrawal bleeding did not occur. The lochia was normal in all patients.

4. Three dosage schedules, with and without ergonovine, have been studied in 169 non-nursing mothers, and the report that large doses of TACE given during a brief period following parturition are as effective as are smaller doses given for a longer period has been confirmed. The ergot is equally effective, whether given in combination with TACE or concurrently as separate tablets and capsules.

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X-Ray Pictures Not Too Important In Coronary Thrombosis

Roentgenology is of little importance in coronary thrombosis either in the acute stage or in the chronic cases. There may be no change in the configuration of the heart or in its size unless there is a large myocardial infarct with cardiac dilatation and subsequent hypertrophy.

A good many cases, probably half, do show cardiac enlargement after recovery and the larger the heart, as a rule, the more extensive has been the damage. In the presence of complicating hypertension or valvular disease the added strain is responsible for at least some of the enlargement.

In a few cases the area of infarction is so extensive that there is a so-called cardiac aneurysm which may be seen in the x-ray picture and may be calcified. However, such an aneurysm in its chronic state, although interfering with the circulation, does not rupture. Rupture of the heart when it does occur takes place within the first fortnight through a necrotic myocardium.—Paul Dudley White, M. D., Boston, Mass.: *World-Wide Abstracts*, Vol. 1, No. 1, p. 11, October, 1958.



MATERNAL HEALTH IN OHIO

Case No. 224

This patient was an extremely obese 28 year old white Para I, cesarean I, who died 24 days postoperative (postpartum). A repeat cesarean section was done at 28 weeks gestation. Her past history revealed extreme obesity of a degree such that she could not be weighed on ordinary scales; weight was estimated at 325 to 350 pounds. She had hypertension with her first pregnancy. The records state she had rheumatic heart disease (not the type or an estimate of the cardiac reserve). Her pelvis was flat. The indication for the first cesarean section was frank breech presentation, pre-eclampsia, mild, rheumatic heart disease and obesity.

She first received medical attention in this pregnancy on August 21, (28 weeks gestation) at the clinic. Return visits then occurred every two weeks until October when they were increased to every week. The laboratory work done revealed nothing remarkable. These included a chest plate, flat plate of the abdomen, complete blood count and serologic tests for syphilis, routine urinalysis, and electrocardiogram. Her only complaint during her prenatal course was of a 2 plus edema of the lower extremities. Her estimated date of delivery was November 9.

She was admitted to the hospital on October 24 for repeat cesarean section (at 38 weeks) which was performed the following day. A low cervical operation was performed and a living child weighing 6 pounds 6 ounces was delivered. The placenta, adherent to the uterine wall, was completely removed piecemeal. The uterine and abdominal incisions were closed in the usual manner. She was placed on antibiotics (Combiotic®) twice a day routinely. Her postoperative course for the first few days was complicated by a mild urinary tract infection. The Combiotic was stopped on the third day and Gantrisin® substituted.

The record does not state when she began having signs of infection but on November 1, a blood culture was reported as positive for hemolytic *Staphylococcus aureus*. Sensitivity tests were not recorded at this point. Chest x-ray was negative and Achromycin® was started. November 2, skin sutures were removed and the wound was clean. The patient's temperature was 104.4° and blood pressure was 170/100. She complained of chills. November 4 the temperature was still elevated and patient brought up blood-tinged sputum. This date Ilotycin® and Chloromycetin® were added to the Achromycin and Gantrisin she was already receiving; the patient was placed in an oxygen tent.

In the days that followed until her death on November 17, she was given transfusions of one unit of whole blood on alternate days, and a vast number of different antibiotics were tried. The organism was sensitive only to Cathomycin®. The patient was simply overwhelmed by the hemolytic *Staphylococcus aureus* infection. Autopsy was performed.

Cause of Death: Septicemia; verrucous endocarditis and multiple abscesses, embolic in origin, in the kidneys and other organs.

Pathological Diagnosis: Subacute bacterial endocar-

TOPIC THIS MONTH:

Maternal Deaths* Involving Infection

ditis, probably superimposed on an old rheumatic endocarditis; Acute embolic abscesses of the kidneys; Chronic diffuse pneumonitis with passive hyperemia of the lungs and liver; (the uterus showed) necrotic decidua tissue; chronic diffuse oophoritis; diffuse salpingitis; necrosis of the fatty and connective tissue.

Comment

The Committee voted this a nonpreventable maternal death. The main discussion at the time of review concerned possible accretion as a cause for the retained placenta and its piecemeal removal. Members wondered whether a hysterectomy at this time might not have been advisable. Certainly this patient could not be considered a good risk for pregnancy with rheumatic heart and extreme obesity, superimposed on the need for delivery by the abdominal route. This would produce a lowered resistance to infection and was undoubtedly a factor in her losing battle against it.

This writer wishes to direct attention to an insidious danger to all pregnant patients, when deaths due to infection are voted *nonpreventable*! Since the days of Lister, infections have been prevented by various means; there is no reason to believe that they should not be prevented in these modern times. There is no evidence that this patient had an infection on admission to the hospital. *Staphylococcus aureus* is looked upon more and more as an institutional infection. If we regard deaths from this source as nonpreventable, there is grave danger that we will not devote the time

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by official representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

and energy necessary for its eradication. Treatment, however good, is never as valuable as prevention!

Case 123

This patient was a 25 year old Para II, who died 49 days following delivery in the 28th week of pregnancy. Her baby weighed 3 pounds 3 ounces and did not survive. Little is known of her past history except that she had had two full-term pregnancies with living children. During this pregnancy she had been seen by her family physician in the fourth month, but had not returned for subsequent visits as requested.

On November 29th she was admitted to the hospital from the emergency room with convulsions. Her admission blood pressure was 210/108, pulse 90, temperature 99.2°F. She had marked generalized edema and a 4 plus albuminuria. Physical examination also revealed a *mitral systolic murmur*. The toxemia was treated with magnesium sulfate, Veratrone® and sedation, plus low sodium diet with good results. After the toxemia was controlled, induction of labor was attempted twice by the use of intravenous Pitocin® without success.

On December 4, a diagnosis of intrauterine fetal death was made. Labor began spontaneously at 3:00 a. m. on December 5, and progressed precipitously being completed by the expulsion of a stillborn infant at 4:35 a. m. This was immediately followed by profuse bleeding and after seven minutes the placenta was manually removed. Bleeding was not controlled and transfusions were promptly started. Consultation was obtained and on the second pelvic examination, approximately two hours after delivery, the consultant made a diagnosis of rupture of the lower segment on the left side.

An immediate total hysterectomy was performed with the patient in shock, and following this procedure the patient began to improve. She received during this period, a total of 3500 cc. of blood. On the first post-operative day, the patient developed a temperature of 103°F, and continued to run a septic temperature curve thereafter. Urine culture was positive for *Escherichia coli* which was moderately sensitive only to Furadantin®, and the blood culture done on December 3, showed hemolytic *Staphylococcus aureus*. She was treated with Combiotic®, Gantrisin®, Furadantin, erythromycin, intravenous penicillin, Chloromycetin®, carbomycin (Magnamycin®), bacitracin to no avail. The blood and urine cultures remained positive.

Chest x-ray on December 29 revealed multiple pulmonary infarcts which were apparently resolving on subsequent films. Flat plate of the abdomen and kidney films were normal. In spite of carefully controlled supportive measures, the patient slowly declined and died on January 23. Autopsy was performed.

Cause of Death: (Certificate)—*Staph. aureus* bacteremia; *Staph. aureus* bacterial endocarditis; toxemia of pregnancy; cerebral emboli, rupture of aortic cusp, multiple renal infarcts, multiple pulmonary infarcts; sepsis. Septicemia.

Pathological Diagnosis: Subacute bacterial endocarditis involving the tricuspid and aortic valve with rupture of the valves; Multiple infarcts and embolization of the lungs and brain; Cerebritis; Cerebral hemorrhage, right, (Small); Multiple infarcts of the spleen and kidneys; Fatty metamorphosis of the liver with cellular degeneration; Abdominal scar.

Comment

The Committee voted this a nonpreventable maternal death by a narrow margin. The patient had the "triad" of complicating features in her pregnancy and labor, any one of which could have proven fatal. It is unfortunate that the record

does not reveal whether or not the patient developed afibrinogenemia but the history supports this contention; a test tube of unclotted venous blood would have confirmed the point.

Obviously this patient did not have adequate prenatal care and this fact provoked some disagreement in the Committee as to whether this might not have been a preventable death with the patient the responsible factor. The variety of antibiotics and chemotherapeutic agents used served to call attention to the immunity of the *Staphylococcus aureus* to these agents and the urgency of preventing infection. This problem assumes increasingly alarming proportions and calls for the best efforts of the medical, nursing and administrative staffs of our hospitals.

Case No. 272

This patient was a 21 year old para I, who died on the twelfth day postpartum. With a last menstrual period June 20, she had had regular prenatal care since the second month of pregnancy. Her general health had been excellent and the prenatal course was entirely uncomplicated except for slight edema of the ankles during the eighth month. Laboratory studies were adequate and the findings normal.

She was admitted to the hospital on April 4 at term, in active labor. The membranes ruptured spontaneously. Labor was described as hard and was terminated by mid forceps over an episiotomy after 14 hours and 25 minutes. The baby's weight was 8 pounds, one ounce and was a live birth. The labor was complicated by third degree extension of the episiotomy. Anesthesia was gas-oxygen-ether mixture, given by a registered nurse anesthetist. The patient was discharged on her seventh postpartum day, apparently with an infected episiotomy, but the records were not entirely clear on this point.

She was visited at home by her physician on the next day. He found the episiotomy grossly infected with purulent drainage and partial separation. She was advised to continue the Achromycin® which she had been receiving prophylactically since her first postpartum day. Her temperature at this visit was 100.5°. The next day, April 13, she was again seen at home and found "moribund." She complained of left shoulder pain, the urinary bladder was distended, the perineum was markedly swollen and tender. Her temperature was 102°; blood pressure 110/80, and pulse 140. She was readmitted at once to the hospital.

The admission temperature was 105.8° and pulse 145. The patient was extremely toxic and medical consultation with an internist was obtained. The patient was allergic to penicillin. Blood culture revealed non-hemolytic *Staphylococcus aureus*. Culture from the episiotomy wound showed hemolytic *Staphylococcus aureus* with an unidentified gram positive coccus. The white blood cell count was 25,900, with 97 per cent polymorphonuclear leukocytes and a hematocrit of 34. She progressed rapidly downhill in spite of supportive treatment, erythromycin, and Aureomycin® intravenously. She died April 15 at about 10:00 a. m., on her twelfth postpartum day. There was no autopsy.

Cause of Death: Severe fulminating staphylococcus septicemia secondary to infected episiotomy wound with pelvic and perineal cellulitis.

Sensitivity studies of the staphylococcus revealed that

it was sensitive to Chloromycetin,[®] erythromycin, and neomycin, but resistant to Aureomycin, Achromycin penicillin, streptomycin, Panmycin,[®] and sulfonamides. This report was received on April 16, one day after the patient died.

Comment

The Committee voted this a preventable maternal death. It was felt that the infection was preventable; sensitivity studies would have been in order earlier. The patient had good prenatal care and was, apparently, in good condition at the time of delivery. The reason for the mid-forceps delivery was *not* recorded! The Committee felt that the patient was sent home too early in view of her infection. After seven days with steady progress of the disease, in spite of prophylactic antibiotic therapy (Achromycin) culture of the purulent material from the episiotomy wound and antibiotic sensitivity test would have led to a more specific therapy. Probably transfusion to increase the hematocrit from the level of 34 would have been helpful. This writer does not believe in prophylactic administration of antibiotics, but he sincerely hopes that if they must be used, the dosage is high enough to be of therapeutic value. If beneficial results are not obtained within 72 hours, the organism is probably resistant to the antibiotic agent used and sensitivity studies are essential, if treatment is expected to be successful.

Comment of the Consultant

The following comment of a consultant, who is a specialist in Internal Medicine, was given at the request of the Committee.

These three cases have one feature in common, that is, overwhelming postpartum infection. The organism in all cases was *Staphylococcus aureus*. This organism has become one of the most difficult problems to handle in the area of infectious diseases and since 1949 this organism when seen, is either initially resistant to most antibiotics or develops such resistance under therapy with great facility. I think it can be said that we have placed *too great* a reliance in recent years upon prophylactic and therapeutic antibiotics and that in the case of hemolytic Staph. aureus the most important consideration is probably the re-institution of very strict sterile technique.

The first case, No. 123, obviously had a very stormy postpartum course and opportunity for infection was great. Considering the magnitude of her problem, I do not see how the infection could have been prevented unless there was a correctible lapse in sterile technique. However, the protocol is not clear as to the level or sequence of antibiotics used and it has been our experience that unless the organism is sensitive to, and the patient receives large doses of a bacteri-

cidal drug, such as penicillin, therapy is probably inadequate. It should be given intramuscularly in the aqueous form and in dosage which gives blood levels 5 to 10 times those shown by *in vitro* sensitivity tests. If the causative organism is not sensitive to penicillin, then the appropriate antibiotic such as chloramphenicol 4 to 6 Gm. per day should be substituted.

According to the protocol, blood cultures done on December 3rd, two days prior to the onset of labor, were *positive* for hemolytic Staph. aureus. This would mean, of course, that the patient actually had endocarditis at the time of admission and I would agree with the comment of the Committee that adequate prenatal care might have conceivably prevented the firm establishment of the fatal staphylococcus infection.

Case No. 224 again shows a bacterial endocarditis, this time superimposed on old rheumatic endocarditis. She had a rather complicated cesarean section and then was placed on Combiotic with a dosage which was probably inadequate and for a rather short period of time. An interim of at least three or four days between the notation of a positive blood culture and the institution of adequate broad spectrum antibiotics which might have had an effect on this organism gave a period of time in which the infection could become firmly established. I would think that the only possible therapeutic measures that might be successful at this time would be the institution of massive doses of either penicillin or perhaps kanamycin.

The final case, No. 272, is one which was obviously preventable with the gross infection of the episiotomy, which was not attended to until the patient was practically moribund. Again I would wonder if the staphylococcus had not engrafted upon a heart valve as in the first two cases.

In summary, we have the tragic evidence of the virulence of the staphylococcus which if given a chance to invade the endocardium, either through the lapse of sterile technique or perhaps by non-preventable complications, can prove rapidly fatal.

In patients with known rheumatic heart disease, penicillin is *routinely* given before and after dental extractions. This use of prophylaxis has never been well accepted in obstetrical cases. Adequate series are not available in the literature. If such drugs are going to be used, especially in complicated cases, adequate dosage 600,000 to 1.2 million units for five days preferably pre and post delivery would be best.

A Clinicopathological Conference

Edited Under the Auspices of the Ohio Society of Pathologists

CHARLES BLUMSTEIN, M. D., *President*

Presentation of Case

THE first admission to the University Hospital, Columbus, Ohio, of this 41 year old white male was nine months before his final admission, when he complained of nausea and vomiting of 24 hours' duration. He had previously been in good health except for measles, mumps, chickenpox, whooping cough, an appendectomy and tonsillectomy in childhood. On the day of onset of symptoms he developed a headache and felt flushed; shortly afterward he became nauseated and vomited every few hours until admission. Later the vomitus assumed a coffee-ground appearance and contained some streaks of blood. He also complained of slight sore throat. There was no associated abdominal pain, melena, constipation or diarrhea.

The family history revealed that the father died from heart disease, mother and sister alive and well. The physical examination on admission showed a temperature of 101 °F., pulse 106, respirations 24 and blood pressure 150/70. The only positive findings were conjunctival injection and marked injection of the pharynx and uvula. His white blood count was 19,200 with 80 per cent polymorphonuclear leukocytes, and his urine was negative to sugar and acetone. A diagnosis of an upper respiratory infection was made and he was treated with Thorazine,[®] Combiotic,[®] intravenous fluids and vitamins. Terramycin[®] produced a slight response, not forthcoming with penicillin and streptomycin. He was discharged on the seventh hospital day.

Following discharge the patient had many similar episodes at intervals of six weeks to two months which usually ran the following course: They started with a clear rhinorrhea and symptoms of a mild upper respiratory infection. On the following day the temperature would rise and the patient would develop a transient blotchy erythema over trunk and limbs with bouts of nausea and vomiting. The vomiting would ease off after about 24 hours, while the nausea and pyrexia would continue for several days. The erythema tended to fade with the onset of vomiting. Headache was usually severe during the first one or two days of these episodes.

Presented by

- Jack Tetirick, M. D., Columbus., and
 - Emmerich von Haam, M. D., Columbus.
- Edited by Dr. von Haam.

The patient was readmitted as a diagnostic problem during one particularly severe abdominal episode.

Physical Examination

The patient was a well developed, slightly obese white male with a temperature of 101.8° F., a pulse of 94, respirations 24 and a blood pressure of 100 over 50. The nasal mucosa, pharynx and soft palate were edematous and the conjunctivae were injected. The fundi were normal. The skin showed a diffuse erythema over the back and face and a blotchy erythema over the anterior trunk and legs. The lungs and heart were normal on percussion and auscultation. The bowel sounds were hypoactive. Neurological and rectal examinations were negative and the lymph nodes were not enlarged.

Laboratory Investigations

The hemoglobin was 13.3 Gm.; the red blood count was 4.5 mil., the white blood count 18,750 with 78 per cent polymorphonuclear leukocytes and no eosinophils. The urine examination showed a specific gravity of 1.026 with mg. protein, no sugar or acetone, and 8 to 10 white blood cells per high power field. The gastric contents and stool were guaiac-positive. The blood urea nitrogen was 28 and 22 mg. Fasting blood sugar was 146 mg. Bromsulphalein test showed 11 per cent retention. The prothrombin time was 88 per cent of normal. Tests for urinary porphobilinogen were negative.

The serum amylase was 50 units. The plasma sodium was 135 mEq., the potassium 3.4 mEq., and the chlorides 94 mEq. The CO₂ combining power was 64 vol. Plasma proteins were 6.2 Gm. with an albumin/globulin ratio of 3.9/2.3. Agglutination tests for typhoid, paratyphoid, Brucella and tularemia were negative. A 12 hour gastric analysis showed 42° of hydrochloric acid, 75°

total acid, and a positive test for occult blood. The Latex fixation test and the lupus erythematosus preparation were negative on two occasions. Sternal marrow puncture showed a significant hyperplasia of myeloid elements with a slight left shift; the megakaryocytes were normal; the blood platelets numbered 336,960.

Hospital Course

On the third hospital day he developed right lower quadrant abdominal pain, distention and rebound right lower quadrant tenderness and guarding. Peritoneal tap was negative. X-rays on admission were noncontributory. The serum amylase was within normal limits. Some hours later he began vomiting a dark brown, guaiac-positive material which later became grossly bloody. His bowel sounds were active. He had a temperature of 101°F. He received whole blood to combat anemia due to bleeding. After 48 hours his hemorrhage appeared controlled.

Following stabilization of his general condition, x-rays showed indentation of the third part of the duodenum with loss of mucosal pattern and some gas bubbles along the hepatic flexure of the colon suggestive of an intestinal perforation. Lower gastrointestinal and intravenous pyelogram studies were normal. Stool guaiac was positive at this stage.

On the 21st hospital day surgical exploration revealed a large retroduodenal and right colic abscess which appeared to be secondary to a perforation of the distal portion of the duodenum. Biopsy reports showed only chronic inflammatory tissue with regional lymphadenitis. Culture of the pus yielded a growth of *Pseudomonas*. A diverting gastrojejunostomy and Stamm type jejunostomy were performed. His postoperative course was satisfactory and he was discharged on the eighth postoperative day.

Six days after his discharge the patient began to get abdominal distention with mild epigastric pain and vomited greenish material containing flecks of bright red blood. On the ninth day he came to the emergency room and while there vomited 250 cc. of grossly bloody fluid. He was readmitted with a temperature of 98 and mild epigastric tenderness. The admission hemoglobin was 14.8 Gm.; his white blood count was 10,000 with 90 per cent polymorphonuclear leukocytes. Serum chloride was 85, serum potassium 3.3 and serum sodium 156 mEq.; CO₂ combining power was 100 vol.

His electrolyte imbalance was treated with some difficulty and he continued to fluctuate between metabolic alkalosis and acidosis. On the third hospital day he spiked temperatures up to 104°F;

his respirations rose to 30 and his pulse to 140. Since the temperature showed little response to tetracycline, he was put on Chloromycetin® and penicillin, and Neo-Synephrine® was added to the intravenous fluids to combat a drop in blood pressure to 80 over 60. He continued to pass rather loose, tarry stools, his hemoglobin dropped from 13.7 to 11.6 Gm., and his general condition began to deteriorate.

His admission pyrexia and tachycardia continued and he became lethargic and icteric. His abdomen remained silent to auscultation from the fourth hospital day on. Two paracenteses yielded 5 cc. of odorless serosanguineous fluid with an amylase content of 50 units. An upper gastrointestinal x-ray showed a patent gastroenterostomy stoma with dilated small bowel containing multiple air-fluid levels. On barium swallow the esophagus showed a configuration suggesting spasm or esophagitis. On the eighth hospital day fine rales became audible over the left base, the patient became cyanotic, unresponsive and cold, and died.

Clinical Discussion

DR. JACK TETRICK: If one were to discuss this patient from the standpoint of major disease categories, such as neoplasia, degenerative diseases, congenital diseases or infection, I believe that one would have to choose septicemia as the basis for this patient's illness. Here is a man too young to die of the common degenerative diseases or neoplastic disorders, who contracts an illness which is too long for what we ordinarily consider an acute surgical disease and yet is fairly rapidly fatal. His disease began with intermittent fever followed by the cardinal signs of sepsis.

One thing which stands out is the pulse of 106 in the face of a temperature of 101. It is significant that his urine did not contain acetone and sugar, because if there is anything that can make infection run an atypical course it is diabetes mellitus. After his discharge from the hospital he developed bouts of fever with headache, nausea and vomiting and a blotchy erythema. That sort of skin rash is often closely associated with an allergy to some auto-immune protein produced during an infection.

He had slight elevation of his Bromsulphalein and his stools were guaiac-positive. Acute porphyria was not present, and a sternal marrow biopsy ruled out leukemia. On his third hospital day he developed signs of an acute abdomen, but he did not have his surgical exploration until his 21st hospital day. That is a long time to wait, and we can only assume from this that his symptoms must have been pretty vague and that he did not just develop definite pain in his abdomen

with localized tenderness. He was having bloody stools and even needed transfusions for it. His x-rays showed evidence of obstruction of the third part of the duodenum with a possible intestinal perforation.

Abscess

At his surgical exploration a large abscess was found that was thought to arise from a perforation of the third portion of the duodenum. But he was sent home and nine days later he had to be readmitted because of severe abdominal pain and vomiting. He had typical severe hypokalemic, hypochloremic alkalosis. The commonest cause of that in a patient with a gastroenterostomy is of course stomal obstruction, and I am not the least impressed if a gastrointestinal series afterwards demonstrates the stoma to be open, because more often than not this is an adynamic phenomenon secondary to some other process within the abdomen, such as pancreatitis or reactivation of his abscess.

Then he developed a lot of difficulty with his fluid and electrolyte balance and went from alkalosis into severe acidosis. There is very little that can produce wide fluctuations in electrolyte balance if the kidneys are working right. So I must assume that the patient's renal output was not what it should have been. Then he went into the "flutter of wings" type of syndrome where you start Neo-Synephrine, and the patient responded somewhat to that. I note that no overt hemorrhage had occurred, but he still had loose, tarry stools and a drop in hemoglobin, so I assume that he was bleeding. He continued to go downhill despite antibiotics, became somewhat jaundiced and died.

Let us consider now what processes might produce this picture. First of all, what about a metastatic abscess such as is most commonly found in patients with diabetes? Usually it takes tissue necrosis in addition to bacteremia to produce metastatic abscesses unless there is severe bacteremia in progress. What about brucella, echinococcus or tularemia? All his agglutination tests were negative and there is nothing to indicate that he had a large cyst in his liver. What about subacute bacterial endocarditis, which is a well-known cause of hidden abscesses? The patient had no heart murmurs, no splinter hemorrhages, and nothing to support the diagnosis of subacute bacterial endocarditis. Intestinal infestations with hookworm occasionally can produce a syndrome like this, but this patient did not come from an endemic area.

Tuberculosis is a possibility, but this patient had wide swings of his temperature and his chest film was reported as clear. Most physicians can count

the number of times in their lifetime that they have had to deal with a disease of the third part of the duodenum. Diverticula are about the only disease entities that occur there with any frequency, tumors are extremely rare, and I think that we have to think that the third part of the duodenum was involved more by chance than by a disease which primarily occurs there with any frequency.

What about conditions that mimic sepsis but are not actually sepsis in their underlying etiology? Agammaglobulinemia of course can produce uncontrolled infections, but it is unlikely in this man, who had lived 41 years, had an appendectomy and the usual childhood diseases. Leukemia of course is famous for producing these symptoms, but we have a bone marrow study to rule it out. I have already mentioned porphyria.

Vascular Occlusion?

What about vascular occlusion? I think that if there had been any thrombosis of a large vessel it would have been noted by the surgeon and treated differently. We can't say that about small vascular occlusions, but we would have to again find some underlying etiology for that kind of lesion. He did have headache and it should be mentioned, at least, that central nervous system lesions can cause ulcers of the gastrointestinal tract and occasionally perforation and death. However, the patient's central nervous system examination was essentially negative on two occasions and we have no good evidence to lead us in that direction.

Foreign Body?

What about a foreign body? Such things as ingested pieces of wood, pins, chicken bones, etc., can produce a slow erosion and perforation of any portion of the gastrointestinal tract with the gradual formation of a large abscess and a septic death. No foreign body was found at surgery, and it also could not explain the first eight months of his illness very well, since I just can't believe that this abscess in his abdomen existed for such a long period. Lymphoma is a common disease which can mimic sepsis. Many things in this patient's illness would fit that. Sore throat as a presenting complaint is particularly common. However, the surgeon would certainly have seen massive nodal involvement and I don't believe that he would have drained an abscess the source of which was a lymphoma without making the diagnosis, and the histology does not lead us in that direction.

I am forced to come down to the group of collagen diseases—lupus erythematosus, periarteritis nodosa, or scleroderma—which are famous for producing a fairly fulminating course in a fairly

young person. It is hard for me to separate one from the other. Lupus of course is usually associated with a leukopenia. It can produce gastrointestinal hemorrhage, it can produce any of the things that this patient had. We are told that he had a change in his esophagus which looked like spasm or stricture, and this suggests scleroderma. He did not have eosinophilia, and this is somewhat, although not definitely, against it.

Periarteritis Nodosa

But certainly any time a patient in this age group presents a septic chart and you can't explain it, you must consider periarteritis nodosa. They do have intermittent fever, they do have a high leukocyte count. Seventy-six per cent are said to have gastrointestinal symptoms including nausea and vomiting. They produce gastrointestinal bleeding by forming hemorrhagic infarcts as the vascular system degenerates. They do produce perforations of the gastrointestinal tract. If I am to make a diagnosis of periarteritis nodosa as the underlying cause of this patient's death, what about the abdominal abscess? I will have to conclude that it was due to perforation of the duodenum as a complication of periarteritis nodosa.

What about the therapy and the patient's terminal course? The patient had his surgery, the abscess was drained and the involved bowel was bypassed. Then he was sent home and developed stomal obstruction. He became quite dehydrated, his urinary output was bad, and he came back into the hospital. I believe the cause of his stomal obstruction probably was reactivation of his septic process and that his terminal episode was probably due to a suppurative pylephlebitis of his mesenteric veins.

Clinical Diagnosis

1. Periarteritis nodosa.
2. Infarction of duodenum with perforation
3. Adynamic stomal obstruction.
4. Sepsis.

Pathological Diagnosis

1. Staphylococcic enteritis with healed perforation.
2. Retroperitoneal abscess.
3. Septicemia.

Pathological Discussion

DR. VON HAAM: The individual appeared well nourished and when the peritoneal cavity was opened no peritonitis was discovered, although there were some postoperative adhesions present. The lungs showed nodular areas of confluent bronchopneumonia. The mucosa of the esophagus

appeared ulcerated. The gastrojejunostomy opening was found patent. The distal portion of the duodenum was markedly thickened and surrounded by dense adhesions. No perforation was found. The remaining portion of the small intestine was distended, markedly hyperemic and the lumen contained gray, turbid fluid with numerous particles of mucus. The large intestine appeared grossly normal. The brain weighed 1450 grams and appeared quite edematous.

Microscopic Examination

Sections through the lungs showed confluent bronchopneumonia with numerous microabscesses and the presence of numerous coccal colonies. Sections through the small intestine showed an inflammatory process involving the mucous membrane as well as the deeper layers of the bowel wall. The inflammatory process was located specifically around the smaller vessels of the gut, which showed the picture of a thrombosing angiitis. While its distributional pattern agreed well with Dr. Tetirick's suggestion of periarteritis nodosa, the histological features of this disease were absent, particularly the eosinophilic necrosis of vessel walls.

It is my interpretation that the patient suffered from recurrent bouts of staphylococcic gastroenteritis with mycotic angiitis simulating periarteritis nodosa of the intestine. I think that the perforation occurred exactly as Dr. Tetirick described, as a consequence of a circumscribed infarct due to a vascular lesion. I believe that this perforation, which later healed, was the cause of the retroperitoneal abscess, and that the patient died from fulminating septicemia of staphylococcic origin.

Many Factors Influence Migraine Headaches

Migraine is apt to occur more frequently in women since it is often associated with menstruation. More than half of the cases of migraine start between 20 and 30 years of age—rarely in childhood or the seventh decade. Occupation and social position have an important influence. It affects country people and manual workers less than mental workers and city dwellers. Physical or psychic trauma may initiate an attack. There is a strong hereditary history. About 50 per cent of the children of migrainous parents develop migraine, 80 per cent from the maternal and 20 per cent from the paternal side. The history of allergy in the family apparently increases the incidence of migraine.—Fred Wittich, M. D., Minneapolis, Minn.: *J. Michigan M. Soc.*, 57:1429, October, 1958.

DON'T FORGET: RESOLUTIONS MUST BE FILED WITH COLUMBUS OFFICE AT LEAST 60 DAYS PRIOR TO 1959 ANNUAL MEETING

Members—delegates or others—who may have in mind asking the House of Delegates of the Ohio State Medical Association to pass on certain resolutions at the time of the 1959 Annual Meeting, Columbus, April 21-24, are advised that every resolution must be filed with the Columbus Office at least 60 days prior to the 1959 Annual Meeting.

The By-Laws of the Association were amended last year to provide for this. The provision will be found in Chapter 4, Section 8, reading as follows:

"Sec. 8. Resolutions. Every resolution to be presented to the House of Delegates for action shall be filed with the Executive Secretary of the Association at least sixty (60) days prior to the meeting of the House of Delegates at which such action is proposed to be taken; and promptly upon filing of any such resolution the Executive Secretary shall prepare and transmit a copy thereof to each member of the House of Delegates. No resolution may be presented or introduced at any meeting of the House of Delegates unless the foregoing requirements of filing and transmittal shall have been complied with or unless such compliance shall have been waived or dispensed with by a vote of at least two-thirds (2/3) of the Delegates present at such meeting.

"The Executive Secretary may cause to be published in *The Journal* in advance of such meeting of the House of Delegates any or all resolutions so filed with him; and upon the direction of the President or the Council the Executive Secretary shall cause to be so published such resolutions as the President or the Council may designate.

"No consideration may be given, or any action taken, by the Committee on Resolutions or the House of Delegates, with respect to any resolution unless such resolution shall have been presented or introduced at the opening session of the meeting of the House of Delegates."

Dr. Austin Smith Resigns After Many Years As Editor of AMA Journal

Dr. Austin Smith has resigned as editor of *The Journal of the American Medical Association*. Dr. F. J. L. Blasingame, executive vice-president of the American Medical Association, stating the resignation was accepted with regret, said that Dr. J. F. Hammond, associate editor of the *Journal*, had taken over Dr. Smith's duties, on December 15.

In a brief memorandum to the A. M. A. Board of Trustees, Dr. Smith said that it is his conviction that after 18 years with the Association there is need for "new blood" in key administrative positions and although he has no immediate plans he hopes to take a much needed vacation. Dr. Smith had served as editor of the *Journal* since 1949. He succeeded Dr. Morris Fishbein. In addition to being editor of the *Journal*, he also had directed the editorial policies of the Association's nine monthly specialty journals.

Dr. John M. Van Dyke, general surgeon in Canton since 1926, has retired from private practice to become health commissioner of that city.

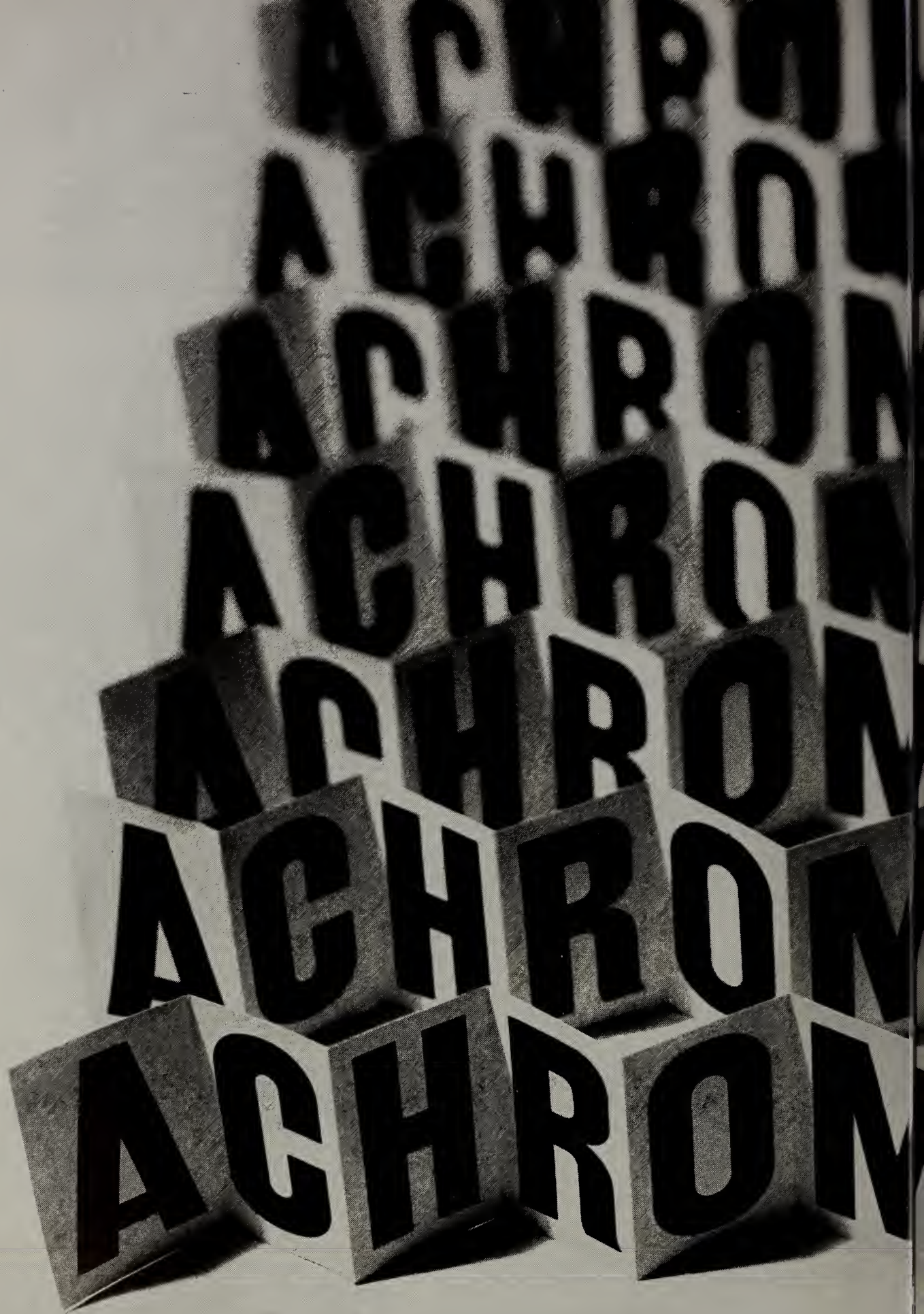
Student AMA Invites Exhibitors For Chicago Spring Meeting

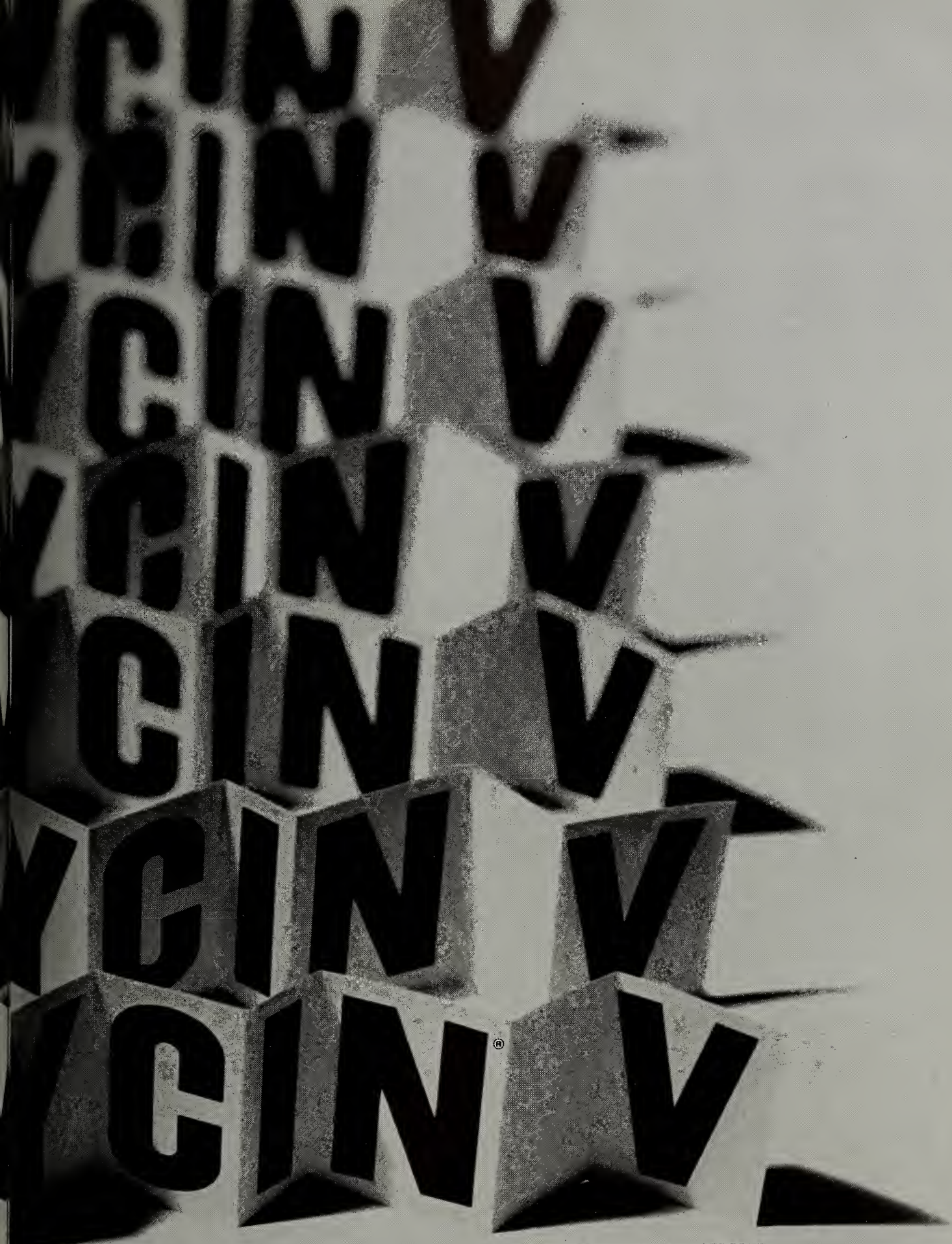
Medical students, interns and residents are being urged to participate in the second annual national Scientific Exhibit Assembly of the Student American Medical Association to be held in Chicago, April 30 - May 2.

The SAMA-Lakeside Laboratories Awards will again be given, with the special honor of free all-expense trips to the American Medical Association convention and the privilege of exhibiting in the AMA's own scientific assembly, for the top student and the top intern or resident.

Applications must be obtained from SAMA (address Mr. Russell Staudacher, Executive Secretary, Student American Medical Association, 430 North Michigan Avenue, Chicago 11, Illinois) and returned no later than February 1. The 40 chosen exhibitors will be announced.

One of the few honorary memberships ever awarded by the American Rhinologic Society has been presented Dr. Kurt Tschiasny, of Cincinnati, for his many contributions in research in diseases of the ear, throat, and especially nose.





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AMA 1958 Clinical Session . . .

Health Care of Aged, Medical Education Expansion and Voluntary Health Funds Among Items Before House of Delegates at Minneapolis

HEALTH care of the aged, medical education expansion, administrative reorganization, report of the AMA Commission on Medical Care Plans, voluntary health agency fund-raising, osteopathy and the report of the Committee to Study AMA Objectives and Basic Programs were among the resolutions and more than a score of reports considered by the House of Delegates of the American Medical Association, December 2 to 5 at the 1958 Clinical Meeting in Minneapolis.

The House adopted a Council on Medical Service proposal that "the AMA, the constituent and component medical societies, as well as physicians everywhere, expedite the development of an effective voluntary health insurance or prepayment program for the (age) group over 65 with modest resources or low family income; that physicians agree to accept a level of compensation for medical services rendered to this group which will permit the development of such insurance and pre-payment plans at a reduced premium rate."

The original statement of the Council on Medical Service recommended that "physicians agree to accept a level of compensation as full payment for medical services rendered" to the aged with modest income. The Ohio delegation protested the use of the words "full payment" and, in effect, commitment of all physicians to the principle of full payment. As a result of their efforts, with Dr. Hudson acting as spokesman, the reference committee deleted the words "full payment" in its report to the House of Delegates.

Free Choice Question

Deferred until the June, 1959, meeting was the Commission on Medical Care Plans report concerning AMA policy on such medical care plans. It was suggested that constituent associations determine their attitude on (1) "Free Choice of Physician—Acknowledging the importance of free choice of physician, is this concept to be considered a fundamental principle, incontrovertible, unalterable, and essential to good medical care without qualification?," and (2) "Closed Panel Systems—What is or will be your attitude regard-

ing physician participation in those systems of medical care which restrict free choice of physician?"

Osteopathy

An Indiana resolution permitting state associations to establish their own relationships with osteopathy was rejected by the House, which directed the Judicial Council to review past House policies and state laws on the question.

Voluntary Health Plans

Delegates, after being informed that a resolution pertaining to united fund drives passed at the June meeting in San Francisco had been the subject of some misinterpretation, resolved that the AMA "neither approves nor disapproves the inclusion of voluntary health agencies in United Fund drives" and requested the Board of Trustees to arrange a top-level conference with voluntary health agencies, United Funds and other parties interested in health fund campaigns, with a view of resolving misinterpretations and other difficulties in this area.

More Schools Urged

On recommendation of the Council on Medical Education and Hospitals and the Association of American Medical Colleges, the House adopted a report encouraging "consideration and creation of both four-year programs of medical education and of two-year programs of basic medical science, where institutions of higher education offer the setting which would make such developments mutually advantageous and desirable."

Purpose of the action was to place AMA in a position of leadership in meeting what the Council termed "the need for constantly increasing the number of physicians."

Reorganization at Chicago

Under a reorganization program approved by delegates, the AMA administrative structure now consists of seven divisions, namely, business, law, communications, field, scientific publications, socioeconomic activities and scientific activities. This includes reorganization of the Washington Office with overall direction coming from Chicago.

Also approved was a plan to promote active liaison with each national medical society to bring

about coordination of the special fields of scientific interest. In other actions, the House:

Took notice of the recent restrictive changes in the **Medicare program**; expressed regret at the substitution of federal facilities for private care in the areas mentioned, and urged the Association to encourage the reestablishment of services under the free choice principle to accomplish the original intent of the act;

Would Combine Aid Programs

Recommended that the Social Security Act be amended by Congress to permit states to combine the present four **Public Assistance** medical programs into a single medical program, administered by a single agency and making available uniformity of services to all eligible Public Assistance recipients in the state;

Authorized the Council on Medical Service to sponsor at the earliest practicable date a **Congress on Prepaid Health Insurance**;

Approved a plan to develop "**Buyers' Guides**" which will be sent to physicians to help their patients analyze the merits of available health insurance programs;

Approved a Bylaw amendment which will allow **dues exemptions** for interns and residents serving in training programs approved by the Council on Medical Education and Hospitals;

Called to the attention of all individuals or institutions responsible for **intern and resident training** that medical services provided to patients in hospitals are the responsibility of duly licensed physicians;

Encouraged the voluntary registration of the **paramedical personnel** who assist physicians, but opposed the extension of governmental licensure and governmental registration at this time.

Newspaper Approved

Heartily approved and lauded the purpose, content and format of **The A. M. A. News** and recommended continuance of the publication under its present and established policies;

Agreed with the Committee on Medical Practices that **relative value studies** should be conducted by each constituent medical association but not on a national or regional basis by the AMA;

Urged each constituent society to establish a committee on **rehabilitation** to carry out activities recommended by the Board of Trustees;

Called for continued activity at all levels to stimulate the development of effective **polio-myelitis inoculation programs**;

Suggested that the Association take immediate steps toward developing a plan whereby reserve

medical units and individuals not immediately involved in military operations could be used to supplement **civil defense** operations.

As directed by the OSMA House of Delegates at the 1958 Annual Meeting, results of a poll on Social Security coverage for OSMA members were filed with the AMA House of Delegates. Results of the poll were as follows: Ballots distributed, 8,960; marked ballots returned, 6,832, representing 76 per cent of the ballots distributed; members voting "yes," 4,095; members voting "no," 2,737; number voting "yes" equal to 45.7 per cent of membership as of October 1, 1958 (8,960).

Ohio's Delegates

Leading Ohio's delegation to Minneapolis was OSMA President Woodhouse; other delegates included Drs. Paul A. Davis, Akron, Charles L. Hudson, Cleveland; Carl A. Lincke, Carrollton; Carl S. Mundy, Toledo; Charles A. Sebastian, Cincinnati; C. C. Sherburne, Columbus, and Herbert Wright, Cleveland; also, Dr. Charles L. Leedham, Cleveland, delegate from the Section on Military Medicine; Walter J. Zeiter, Cleveland, delegate from the Section on Physical Medicine, and alternates Robert S. Martin, past-president, OSMA, Zanesville; Paul F. Orr, Perrysburg, and H. T. Pease, Wadsworth.

Dr. Hudson served as a member of the Reference Committee on Insurance and Medical Service. Dr. Woodhouse is a member of the Judicial Council and Dr. Lincke, a member of the Council on Scientific Assembly.

Present Papers

Presenting papers at the meeting were Drs. H. Wm. Clatworthy, Jr., Columbus; Claude S. Beck, Hymer L. Friedell and Harriet P. Dustan, all of Cleveland. Scientific exhibitors from Ohio included Drs. N. J. Giannestras, Ralph G. Carothers, Harold S. Shiro and Jay Shanon, Cincinnati; H. S. Van Ordst, W. R. Biddlestone, L. J. McCormack, V. E. Reinking, W. James Gardner and Donald F. Dohn, all of Cleveland. Among medical motion pictures presented were films by Dr. Willem J. Kolff, Cleveland, and Dr. Roger D. Williams, Columbus.

At a conference on Federal Medical Services in Minneapolis December 1, Dr. Hudson was a member of a panel on "Where Do We Go on Medicare" and Dr. Robert S. Green, Cincinnati, served on a panel which discussed "Are Education and Research Essential to Veterans' Medical Care?"

Attending the Clinical Meeting from OSMA Headquarters were Hart F. Page and Charles W. Edgar.



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Manager Columbus, Ohio
(Name of Hotel)

You are requested to reserve the following accommodations during the period of the Annual Meeting of the
Ohio State Medical Association, April 21-24, 1959, or for such other period as may be indicated herein.

☐ Single Room with Bath ☐ Double Room with Bath Price
☐ Twin Bed Room with Bath ☐ Other

Arriving April at A. M. P. M.

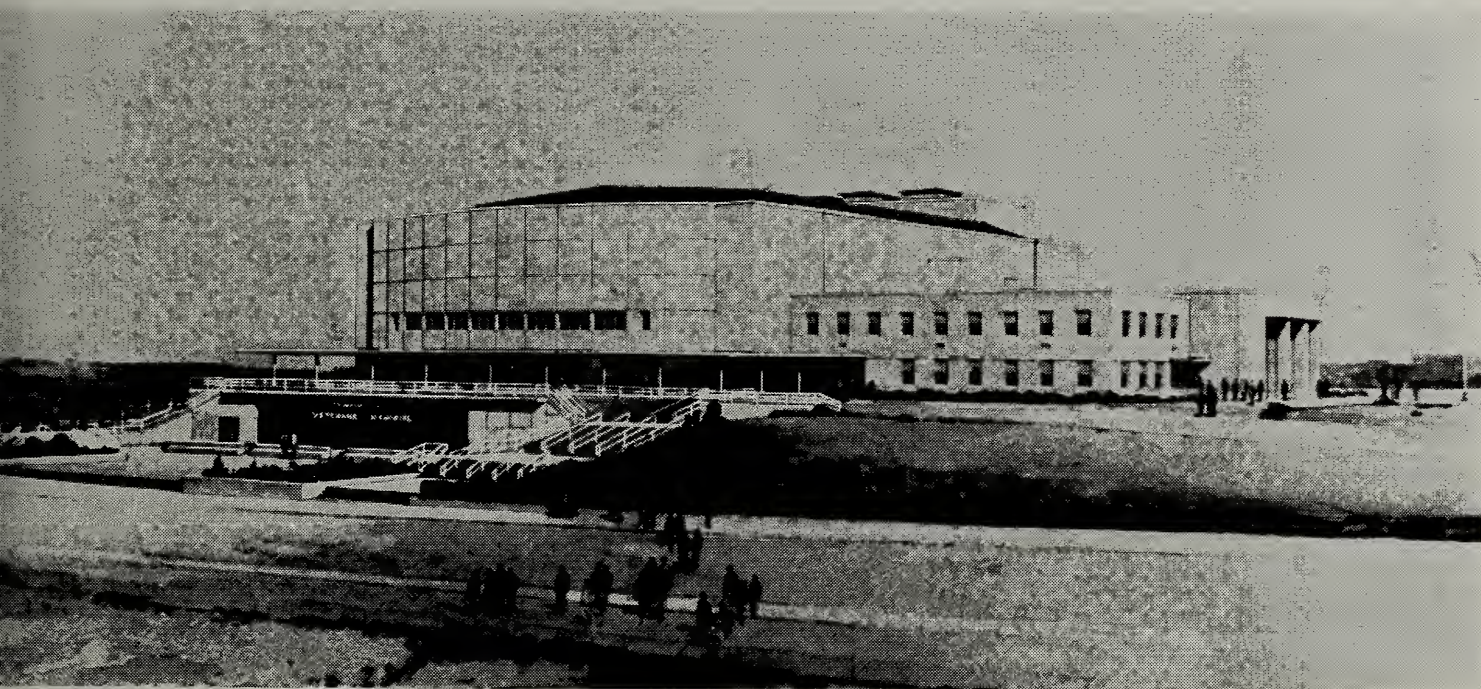
PLEASE VERIFY MY RESERVATION

Name

Address

Center for 1959 Annual Meeting . . .

Discussion on Food Faddism, Symposium on Trauma Are Two of the Many Features of 1959 OSMA Annual Meeting in Columbus, April 21-24



Here is the spacious Veterans Memorial Building in Columbus where most events of the 1959 OSMA Annual Meeting will center. The dates are April 21-24. Several outstanding features of the Annual Meeting program follow:

* * *

ONE important feature will be a panel discussion on the subject "Food Faddism."

Top persons in the national fight against food quackery will participate in the discussion and review what is being done on the national level. The panel will consist of Warren Whyte, attorney with the Law Division of the AMA, who will be chairman of the panel; Kenneth Milstead, Ph. D., director of the Division of Regulatory Management, Bureau of Enforcement, Food and Drug Administration, Washington, D. C.; Oliver Field, director of the AMA Bureau of Investigation; and Miss Maye Russ, director of the Drug and Cosmetics Division of the National Better Business Bureau, New York.

Another feature will be the Symposium on Trauma. Among speakers in this session will be Dr. Oscar P. Hampton, Jr., St. Louis, Mo., who will discuss, "The Triage System for Civilian Mass Casualties"; Dr. Robert Kennedy, New York City, whose topic will be "The Care of the Multiple Injured Patient," and Dr. E. Thomas Boles, Jr., Columbus, who will discuss "Trauma

in Childhood." Other phases of the subject to be discussed will include the ideal emergency room for trauma cases, and the handling of trauma cases in the office.

On Tuesday, April 21, The Ohio State Heart Association and the Ohio Division of the American Cancer Society will sponsor programs in their respective fields at general sessions on the OSMA program.

The Ohio State University College of Medicine is collaborating with the OSMA in sponsoring the Friday, April 24, program. This is in connection with the 125th anniversary of the OSU College. Additional features of the University celebration will be held on the campus the following day.

Other features of the Annual Meeting will be: The Scientific and Educational Exhibits; Technical Exhibits; Specialty Section meetings; meetings of the House of Delegates; meetings of the Woman's Auxiliary; The Annual Banquet, and other events.

Those planning to attend should make hotel reservations promptly. A form for making reservations will be found on facing page.

**APPLICATION FOR SPACE, SCIENTIFIC AND EDUCATIONAL EXHIBIT,
OHIO STATE MEDICAL ASSOCIATION, 1959 ANNUAL MEETING,
VETERANS MEMORIAL BUILDING, COLUMBUS, O., APRIL 21-24**

1. Title of Exhibit: _____

2. Name(s) of Exhibitor(s): _____

Institution (if desired): _____

City _____

3. Description of Exhibit: (Attach 200 word description to this blank)

4. Exhibit will consist of the following: (Check which)

Charts and posters _____ Photographs _____ Drawings _____ X-rays _____

Specimens _____ Moulages _____ Other material _____

(Describe)

5. Booth Requirements:

Length of back wall needed? _____

Square feet needed? _____

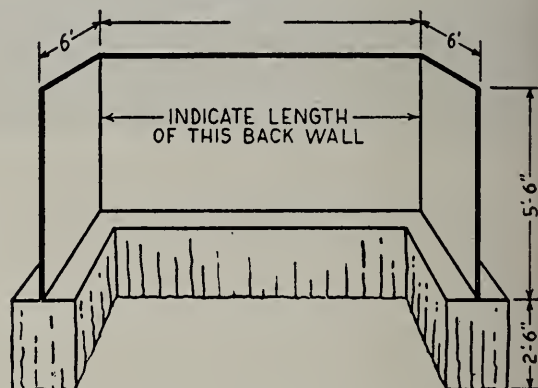
Shelf desired? (yes or no) _____

6. Transparency Cases:

Needed? (yes or no) _____

If answer "yes," give following information:

Number of transparencies to be shown and size of each _____



Booths will have a back wall and two side walls. The side walls of all booths will be six feet wide. Back wall and side walls are eight feet high. If standard shelf is used, only 5½ ft. will be available for exhibit material. For most exhibits, a back wall, eight feet long will be sufficient. With the two 6 ft. long side walls, this gives a total of 110 square feet of wall space.

(It is suggested that transparencies should be no larger than 10 by 12 inches in order to conserve space. For size of view boxes which will be supplied by the Ohio State Medical Association if requested by you and how films should be mounted, see pages 3 and 4 of folder "Regulations and Information, Scientific and Educational Exhibit, Ohio State Medical Association.")

Date _____

Signature of Applicant

Mailing Address, Street

City, Zone, State

**SEND APPLICATION TO: COMMITTEE ON SCIENTIFIC AND EDUCATIONAL EXHIBITS,
OHIO STATE MEDICAL ASSOCIATION, 79 EAST STATE STREET, COLUMBUS 15, OHIO**

Increase of \$5.00 in Annual Dues Recommended By The Council for House of Delegates Action

AT A MEETING on December 13, 1958, The Council of the Ohio State Medical Association by a unanimous vote adopted the following statement recommending that the House of Delegates vote an increase of \$5.00 in the per capita annual dues, effective January 1, 1960.

* * *

For compelling reasons which are enumerated herein, The Council of the Ohio State Medical Association recommends to the House of Delegates that it adopt the following resolution at the 1959 Annual Meeting, April 21-24, in Columbus:

BE IT RESOLVED, That the per capita annual dues of the Ohio State Medical Association be increased \$5.00, effective January 1, 1960, making the total amount of annual dues, \$30.00.

This action was taken by The Council on December 13, 1958, after a careful analysis of the current financial picture of the Association.

The Council is convinced that the Association will need additional funds in order to carry on present activities and programs effectively and to finance additional activities and services which the membership expects.

As this statement will point out, the House of Delegates last year and in the past several years has mandated the officers, The Council and the committees of the Association to undertake certain specific programs. Therefore, The Council believes the House of Delegates will want to provide adequate funds to carry on these activities in a satisfactory manner.

In recommending an increase in dues, The Council is looking to the future. By good management the Association lived within its income in the calendar year, 1958. It could not have met unusual expenses, however, without dipping into Association reserves which have been set aside for emergencies or special projects. The reserves now total \$120,000—a modest amount for an organization with an annual budget of more than \$200,000. We do not want to engage in deficit financing. We believe necessary activities and programs should be financed out of current income.

Being convinced that the membership will want the Association to continue with its present activities and services and will want the Association to expand its work to meet future needs and problems confronting the medical profession, The Council strongly recommends that the House of Delegates take steps immediately to assure resources which will enable The Council to plan ahead.

A detailed look at some of the principal reasons underlying our action follows:

MEMBERSHIP INCREASE: In December, 1955, when The Council recommended that the dues be raised to \$25.00, the membership of the Ohio State Medical Association was 8,600. Since then there has been a 600 increase in membership.

Obviously, this membership increase has been accompanied by many more requests for personal services on the part of the Columbus Office. The workload of the office has increased proportionately.

Since 1955, it has been necessary to employ one additional member of our administrative staff for field work, committee assignments, and general office work.

At present, additional stenographic personnel is badly needed because of the increase in correspondence with members, additional bulletin work and extra clerical work. More members mean more service and more services mean heavier expenditures.

While it is true that an increase in membership means an increase in income from dues, this amount at the current per capita dues is far from enough to properly finance necessary expansions of the Association's services and programs.

Incidentally, it should be pointed out that a percentage of our membership who are retired because of age or disability receive all benefits and services, including *The Ohio State Medical Journal*, but are not assessed annual dues. This is in conformity with the Constitution and By-Laws of the Association. In 1958, of the 9,200 members, 338 were not assessed annual dues; in 1955, the figure was 233.

POPULATION INCREASE: Ohio's population is growing rapidly. This will result in an annual increase in our physician population. There-

fore, expansion of Association membership year by year may be anticipated.

Growth of the State has been accompanied with growing pains in the fields of health and medical care. New problems and challenges have arisen as Ohio's complex industrial economy has expanded. We can expect this condition to continue—become more serious.

So, the Association must prepare now for expansion of its facilities so it will be ready to (1) provide services to a greater number of individual members; (2) provide programs and activities designed to meet the health needs and demands of our ever-increasing population; (3) enable the Association to battle successfully with the vital issues which confront the medical profession now, and which will become more acute and numerous, as our social and economic life becomes more complex. There has never been a time when there has been a greater need for a strong, militant and well-financed Association.

THE OHIO STATE MEDICAL JOURNAL: Costs of printing *The Journal*, one of our most important as well as one of our most costly activities, are closely related to labor costs of the printing industry which are among the highest of the skilled trades.

In 1955, *The Journal* printing costs were approximately \$55,500. In 1958, this figure totalled about \$94,000. These figures do not include payroll or miscellaneous expenses of *The Journal*.

We have been advised by the firm which prints *The Journal* of a 3 to 4 per cent increase in printing costs during 1959, as well as a 7 per cent increase in paper costs.

We have not been lax in boosting advertising rates from time to time but such increases are never able to keep pace with publishing costs. Naturally, we can't afford to price ourselves out of the market by charging exorbitant advertising rates.

For the past two years the Association has had to make an annual subsidy payment from general funds to *The Journal*, amounting to between \$35,000 and \$40,000. Back in 1955, this subsidy was \$27,000. We know of no way to relieve the Association of this financial contribution to *The Journal*—in fact we will be fortunate to keep the annual payments to the current figure.

The paradox of *The Journal* is that an increase in advertising space means that there must be a proportionate increase in the total number of pages in each issue. More pages mean higher printing costs. Moreover, an increase in membership (circulation) means we

must print more copies of each issue, which adds to the printing costs.

How *The Journal* has grown in size and circulation during the past several years is shown in the following data: In 1955, the total number of pages was 1,282. The 1958 volume consisted of 1,688 pages—an increase of slightly over 400 pages. This has placed a much heavier load on our *Journal* staff. Right now an addition to *The Journal* staff to assist in copyreading, proofreading and stenographic services is badly needed.

NEW ACTIVITIES; NEW COMMITTEES: Since 1955 when the last increase in dues was recommended by The Council, the Association has established six important and quite active new committees.

Four of these were mandated by the House of Delegates, namely: Committee on Care of the Aged, Committee on Traffic Safety; Committee on Poison Control, and Committee on Laboratory Medicine.

The other two new committees referred to are the Committee on Federal Legislation, named to confine its activities specifically on Federal legislative matters, and the Committee on Medical Services, set up by The Council to handle such matters as Medicare, Veterans Administration medical care program, other medical care plans.

The House of Delegates—and the members—expect these committees to do a good job. Some of the committees are just getting started in their activities. Unless the budget is expanded to permit more expenditures for committee work, these new committees will be greatly handicapped.

Costs of our committee activities now total about \$15,000 to \$16,000 annually. When these new committees get into high gear, the present amount will be quite inadequate. More revenue will be the answer to this problem.

LEGAL EXPENSES: The Association has found it wise as well as necessary to employ the best of legal counsel. Matters requiring legal review have multiplied greatly in recent years.

The two important statements of policy, one on third-party plans and one on corporate practice, issued during 1958 are typical examples of why competent legal advice and guidance are needed by the officers, Council and committees of the Association.

Moreover, more and more questions affecting the medical profession of the State as a whole and requiring review by our legal counsel are being submitted to the Association for determination.

These include matters involving professional

ethics; disciplinary actions; interpretations of the Constitution and By-Laws of the Association and those of the county medical societies; legislative proposals; etc.

Naturally, legal expenses vary, depending on the amount of work required. No arbitrary figure can be determined in advance. However, the following figures will indicate to some extent what our legal expenses are running and how they have increased. In 1955, legal expenses totalled approximately \$5,900. In 1958, we paid around \$10,500 for such services.

Such services are indispensable. We must be prepared to obtain the best when we need them.

ADDITIONAL OFFICE SPACE: In order to provide our Columbus staff with adequate space, we recently authorized the rental of 940 square feet adjoining our present office. The additional annual rent is \$2,880. This new space also provides facilities for meetings of The Council and committees.

EQUIPMENT: It is necessary to keep our staff supplied with modern, up-to-date equipment. Each year a certain amount of office equipment has to be replaced. As physicians who have purchased office and professional equipment well know, costs have soared. The end of the era of inflated prices is not in sight. Thus, we must make available more funds than in the past for capital replacements.

POSTAGE, UTILITIES AND SUPPLIES: Costs of these essential accessories in the operation of our headquarters have been increasing steadily.

In 1958 we spent \$500 more than in 1955 for stationery and supplies. (More members equals more letters, more bulletins.)

The postage account in 1958 was \$1,000 more than in 1955. This will go higher as postage rates have been hiked and more increases are promised.

Telephone and telegraph rates have been raised and additional raises are pending. The amount paid for telephone-telegraph services in 1958 was about \$1,000 more than in 1955.

TRAVEL COSTS AND REIMBURSABLE EXPENSES: Those who have done any amount of travelling know that costs of transportation, hotel accommodations, and food have skyrocketed. The result has been a substantial increase in the costs of field work by our staff.

The same applies also to the amount which is now being paid out annually as reimbursement to officers, Councilors and committee members for

their out-of-pocket expenses while on official business for the Association, primarily attending meetings in Columbus.

Committee expenses are running between \$6,000 and \$7,000 higher than four years ago, due largely to increased costs of travel, because new committees have been established and because all committees have become more active. Continuation of this trend appears to be a certainty.

ANNUAL MEETING COSTS: At one time we could be reasonably sure that the income from Annual Meeting exhibits would more than cover Annual Meeting costs. Some of that revenue could be counted on for routine operating costs.

This has changed. Now we are lucky to break even on Annual Meeting expenses because of increases in the costs of transportation and accommodations for our guest speakers, rental of convention space, labor involved in setting up the meeting, events where food is served, expansion of Scientific Exhibit (the cost of which is \$5,000-\$6,000 annually) promotional material, etc.

This is the biggest event sponsored by the Association. For that reason adequate provisions must be made in the budget for it, even if some of the expense must be borne from general funds.

RETIREMENT FUND: Our employees' pension-retirement program has been in effect for 12 years. Six employees are now covered. If normal conditions prevail, seven additional employees will become eligible during the next four years.

Because of the mature age of most of our employees, this will add around \$6,500 annually to the payments of the Association to the pension-retirement fund.

This program has been an important factor in securing and retaining experienced and efficient employees. Obviously, we are obligated to fulfill this agreement between the Association and our employees.

OTHER PUBLICATIONS, BULLETINS, ETC.: The *OSMAgram* continues to be one of our best and most popular media of communication with members. We have found it necessary, also, to send special bulletins and pamphlets to the membership from time to time.

Costs for such activities have increased because of our membership increase, raises in printing prices, hikes in the cost of literature which is purchased, and postage increases.

We dare not re-trench in this field of com-

munications; actually we must be prepared to step up our activities in this field.

PUBLIC RELATIONS: This continues to be a growing field of activity. As stated previously, we must be ready to expand rather than curtail our public relations work.

The American Medical Association calls on us more and more to provide the public with accurate information on medical matters and on the policies of the medical profession on public issues.

We have been asked to participate in the nationwide drive of the AMA against food and diet quackery.

We must continue to emphasize to the public why a close patient-physician relationship is essential to good medical care.

We have to be prepared to give the public accurate data on such subjects as medical education, supply of physicians and voluntary insurance plans.

We must sit in conference with representatives of many organizations as they discuss medical-health questions in order to see that the medical profession's views are properly presented and evaluated.

We must give more help to the county medical societies in this field.

Money and manpower are necessary to handle these responsibilities effectively. There must be adequate provision in the budget for the growth of our public relations program.

COMPARISON OF STATE DUES: The current dues of the Ohio State Medical Association (\$25.00) are exceedingly low. Although we are one of the largest of the state medical societies, our dues are lower than those of most of the societies. No society has lower dues. The following data assembled in June, 1958, show the annual dues and assessments at that time of the various State Societies, revealing that Ohio is in the lowest category:

Societies charging \$25.00 (none have dues less than \$25.00): Ohio, New York, South Carolina, Tennessee, Virginia, West Virginia (plus \$3.00 scholarship assessment) and Wyoming.

Societies charging \$30.00: Arkansas.

Societies charging \$33.00: Connecticut.

Societies charging \$35.00: Kentucky, Massachusetts, Missouri, Nebraska, Washington.

Societies charging \$40.00: Florida, Georgia, Idaho, Illinois, Indiana, (\$10.00 earmarked AMEF), Kansas, New Hampshire, New Jersey, North Carolina, Pennsylvania.

Societies charging \$42.00: Oklahoma (plus \$35.00 building assessment).

Societies charging \$45.00: Vermont.

Societies charging \$50.00: Alabama, California

(\$10.00 earmarked AMEF), Delaware, District of Columbia, Louisiana, Mississippi, Oregon, Rhode Island, Texas (\$15.00 earmarked building fund).

Societies charging \$53.50: Montana.

Societies charging \$55.00: Maine, Minnesota.

Societies charging \$60.00: Colorado (plus \$15.00 special assessment), Michigan (\$10.00 earmarked building fund).

Societies charging \$70.00: Arizona (\$10.00 earmarked AMEF), New Mexico.

Societies charging \$75.00: North Dakota, South Dakota, Wisconsin.

Societies charging \$85.00: Iowa (\$10.00 earmarked student loan fund).

Societies charging \$100.00: Nevada (\$20.00 earmarked AMEF).

Societies charging \$140.00: Utah (\$20.00 earmarked AMEF).

Western Reserve Law-Medicine Center Offers Program February 13-14

Western Reserve University's Law-Medicine Center offers another two-day institute on February 13 and 14, 1959, entitled "The Extremities: A Law-Medicine Problem," which will be presented for lawyers, doctors, insurance claimsmen, industrial relations personnel, labor union officials, and others interested in personal injury and workmen's compensation.

Two special lecturers are scheduled. Dr. Earl D. McBride of Oklahoma City will present material on "Disability Evaluation." He is consultant to the American Medical Association's Committee on Medical Rating of Physical Impairment and author of medical volumes on disability evaluation. Dr. Ernest Johnson, the other main speaker, is with the Ohio State Rehabilitation Center in Columbus. He will lead discussions on "Subsequent Reconstructive Procedures."

Cleveland specialists who will offer lectures are: Dr. Joseph E. Brown, "Anatomy and Physiology of the Extremities"; Dr. George S. Phalen, "Disease and Injury of the Upper Extremities"; Dr. Sam G. Stubbins, "Disease and Injury of the Hand"; Dr. James I. Kendrick, "Disease and Injury of the Lower Extremities"; Dr. Wallace S. Duncan, "Immediate Reconstructive Procedures"; and Dr. Russell P. Rizzo, "Law-Medicine Cases."

Tuition fee is \$25.00. The program will be held in the Newton D. Baker Memorial Building, Hatch Lecture Hall. For further information contact Oliver C. Schroeder, Jr., Director, The Law-Medicine Center, 2145 Adelbert Road, Cleveland 6, Ohio.

More Rehab Funds Needed . . .

State Bureau Emphasizes Job Which Should Be Done in Ohio and What It Will Cost in the Budget Proposal for the Next Two Fiscal Years

VOCATIONAL rehabilitation makes economic sense. It increases productivity and decreases dependency. Ohio, given a larger and stronger program of vocational rehabilitation services, can prepare for and place in suitable employment many more of its vocationally handicapped citizens than it is doing now or has done in the past.

These points are emphasized in a biennial budget proposal filed by the Bureau of Vocational Rehabilitation, Ohio Department of Education, with the State Finance Director, and which will come before the State Legislature for consideration during its next session, starting in January.

The proposal tells what has been done by the Bureau; what improvements in the official rehabilitation program in Ohio are needed; how much money will be required to do the job.

The following is based on data contained in the memorandum which accompanied the budget request for the biennium beginning July 1, 1959 and ending June 30, 1961.

What's Been Done

During the year ending June 30, 1958, a total of 1,286 of Ohio's disabled persons entered employment after receiving rehabilitation services from the Bureau, at a cost to the State of only \$347,076. (As a grant-in-aid program, the Federal share added to this \$576,582.) The combined earnings of those rehabilitated increased from \$816,920 per year at the time of acceptance for service to \$3,442,452 at the time their records were closed.

Of those rehabilitated, 178 were receiving public welfare assistance at the rate of \$238,680 per year when accepted. They were *all* removed from relief rolls as a result of the Bureau's services. These people are once again employed taxpayers.

Survey Recommendations

The Ohio Board of Education has accepted, in principle, recommendations made concerning the Ohio rehabilitation program by the Office of Vocational Rehabilitation, U. S. Department of Health, Education and Welfare. These recommendations contemplate the rehabilitation of \$10,000 disabled Ohioans per year by 1966!

Talk To Your Legislator

It is suggested that physicians who believe it would be good business for the State to improve its Vocational Rehabilitation Program get in touch with their State Representative and State Senator, urging them to provide the Bureau with enough funds to do a better job. Facts which can be used in the discussion will be found in the accompanying story.

On June 30, 1958, 2,644 disabled persons on the Bureau's "referred list" were awaiting plan development for their rehabilitation while the "live roll" stood at 2,562. The active load for the year totaled 4,191, while 1,286 entered employment.

Deficiencies Listed

Ohio today rehabilitates through the services of this Bureau, only 15 disabled per 100,000 population while the national average is 43 per 100,000. In this respect, Ohio rates 52 among 53 states and territories. The basic reason for this is that Ohio's per capita tax support for vocational rehabilitation was 5.1 cents compared to the national average of 14 cents; Ohio ranked last.

In view of the foregoing data, and with only slightly less than 13 per cent of those eligible receiving the Bureau's services, positive action is necessary, the Bureau contends.

Need for More Counselors

The Bureau's 35 vocational rehabilitation counselors today are faced with the task of serving the disabled at a counselor per population ratio of one to more than 250,000. Experience in comparable states has shown that, in any area, there are disabled people who need and can profit from service in numbers that would tax the skilled efforts of one counselor per 100,000 population.

The vocational rehabilitation counselor is the key to the proposed program, which anticipates the addition of 15 counselors and supporting staff (field medical consultants, clerical help, etc.) in each year of the biennium, reducing the ratio to

Poison Information Centers in Ohio

These centers have agreed to cooperate in a program to extend their services to any physician requesting information from them. When a center is called the physician should have four basic facts in mind: (1) The full name or brand of the product ingested or inhaled; (2) An accurate estimation of the amount of the particular agent ingested; (3) The time of ingestion; (4) The age and weight of the patient.

Location	Facility	Telephone
Akron	Children's Hospital W. Bowery and W. Bechtel	BL 3-5531, Ext. 246
Cincinnati	The Academy of Medicine of Cincinnati 152 E. Fourth St.	PA 1-2345
Columbus	Children's Hospital 561 S. 17th St.	CL 8-9783
Cleveland	Cleveland Academy of Medicine 2121 Adelbert Road	CE 1-4455
Springfield	City Hospital E. High St. and Burnett Rd.	FA 3-5531, Ext. 226
Toledo	Toledo Health Department 635 N. Erie St.	CH 4-1961—(Day) GR 9-2244—(Night)

one counselor per 150,000 population in 1961. While Ohio's recommended ratio is one counselor per 100,000 population, recruitment problems, etc., would not allow for meeting this ratio during the coming biennium.

Money Which Is Needed

To finance this program, the Bureau is asking that Ohio increase its direct appropriations \$248,000 in fiscal year, 1959-1960, and \$184,000 more in fiscal year, 1960-1961. The Federal Government will match these funds at a ratio of 57-59 per cent or approximately \$1.25 for each \$1.00 of Ohio money. For special projects which promise substantial contributions to extension and improvement of state rehabilitation services, the Federal matching ratio is 75 per cent or \$3.00 for each \$1.00 of Ohio money. Five such projects are presently in operation and \$40,000 are earmarked for additional community services projects in each year of the biennium.

If the Legislature approves the budget submitted by the Bureau, the Bureau will have available for all purposes, state and Federal money totalling \$1,446,248 for the fiscal year, 1959-1960, and \$1,818,456 for the fiscal year, 1960-1961. In the fiscal year, 1958-1959 the actual expenditures by the Bureau totalled \$951,201 of which the State share was \$353,962; Federal share, \$597,239.

Farm Group Hears What OSMA Is Doing About Physician Distribution

At the Leadership Training Conference of the Ohio Farm Bureau Federation, held December 5 in Columbus, Executive Secretary Charles S. Nelson answered questions concerning problems of physician distribution and discussed the work of the Ohio State Medical Association in solving these problems.

The tangible performance of the OSMA in this field includes the following services outlined by Mr. Nelson: The OSMA physician placement service; The OSMA Rural Medical Scholarship; the Preceptorship Program, conducted in cooperation with the medical schools; The OSMA series of talks to medical students; and the support by Ohio Doctors and their Association of projects and legislation to expand and improve medical education facilities.

Cancer Study

A method for mass screening of population groups for incipient lung cancer will be tested by Veterans Administration and the American Cancer Society. The technique involves examination of sputum specimens. In the joint VA-American Cancer Society study about 8,500 residents of six VA domiciliary homes will be screened twice a year.

Legislative Outlook . . .

Situations in 103rd Ohio General Assembly and 86th Congress Are Previewed; Some of the Anticipated Bills Are Listed and Discussed Here

SWEEPING changes in the membership of the Ohio General Assembly and in the next U. S. Congress resulting from the last November 4 election present a definite challenge to the medical profession of Ohio.

There will be many new legislators in both bodies which complicates the matter of winning the ear of legislators and providing them with the point of view of the medical profession.

The fullest cooperation from alert and informed legislative committeemen and officers of the County Medical Societies will be necessary during the ensuing year. The Columbus Office staff and the State Legislative Committee are busy setting up the procedure for securing information on all bills and getting the information to the local committees, urging action pro and con in line with policies laid down by The Council of the State Association.

This article presents information on the situation in the State Legislature and in the Congress and a review of some of the proposals in the medical-health field which probably will be introduced.

Assembly Opens January 5

The regular Session of the 103rd Ohio General Assembly will convene in Columbus at 2 p. m. on Monday, January 5.

Ten Democrats and two Republicans will be serving their first terms in the Ohio Senate. However, four of the 12 have previously seen service in the House of Representatives. The Senate will number 33 this session, with 20 Democrats and 13 Republicans on the roster.

Many First-Termers

On the House side there will be 40 first-term Democrats and seven of the Republicans will be serving for the first time. The party lineup in the House will be 78 Democrats and 61 Republicans.

There will be a change in leadership, occasioned by the fact that in the November election the Democrats secured a majority in both houses. The Republicans have been in the majority in the General Assembly in recent years, the one exception being 1949, when the Democrats organized both House and Senate.

Last session the lineup in the Senate was 22

Republicans and 12 Democrats; in the House, 97 Republicans, 42 Democrats.

Democrats In Control

Possessing a majority brings with it certain privileges. In the Senate it permits the organization of the Senate, including selection of President Pro Tem and Clerk and the appointment of the Chairmen and majority members of Senate Committees.

In the House the majority is able to organize that body, select the Speaker, Majority Leader, Clerk, Chairmen of the committees and majority members of the committees.

Senate Leaders Selected

At a caucus held in Cleveland the Senate Democrats chose Senator Frank King of Toledo as candidate for President Pro Tem of the Senate. Former Senate Minority Leader Joseph W. Bartunek of Cleveland was chosen for the position of Senate Clerk.

The Senate Republicans met December 17 and designated Senator C. Stanley Mechem of Nelsonville as Minority Leader. Last session he served as President Pro Tem.

Election of these nominees when the Assembly convenes on January 5 is assured.

House Leaders Nominated

Meeting in Columbus December 5 the majority members of the House selected James Lantz of Lancaster for Speaker. Other officers will include Jesse Yoder of Dayton, Majority Floorleader; Arthur Milleson, Freeport (Harrison Co.), Clerk; and Norman A. Fuerst, Cleveland, Majority Whip.

The Republican minority chose Roger Cloud of Bellefontaine and Kline Roberts of Columbus as Minority Floorleader and Minority Whip, respectively. In the last session they served as Speaker and Majority Floorleader.

Some of the Bills Anticipated

Speculation as to the legislative proposals which may be introduced during this session of the General Assembly provides a long list of measures related to medicine and health. Some will be supported by the OSMA, others will be opposed. Here are some possibilities:

Various amendments to strengthen the Ohio Medical Practice Act by increasing penalties for

practicing medicine without a license and adding an injunction to the present penalties. Also, a bill to raise more money for Board operations.

Legislation by anti-vivisectionists to repeal the law enacted last session to make available abandoned and unclaimed dogs for medical research and teaching.

Proposals on behalf of several paramedical groups asking for licensure by the State of Ohio and for their own licensing boards.

Requests from chiropractors and other limited practitioners for separate licensing boards.

Adequate appropriations for the medical and hospitalization program for the Division of Aid for the Aged; for the operation of the Ohio Department of Health; and for the Bureau of Vocational Rehabilitation.

Legislation to increase the annual salary of the Ohio Director of Health; to permit Ohio to enter into reciprocity compacts with other states for the care of the mentally ill; and to set up a community mental health services act.

Requests for the Legislative Research Commission to make a study of the present method of appointing district boards of health; and to study the financing of health departments.

Outlook In Congress

The 86th Congress of the United States, which convenes January 7 will have heavy Democratic majorities in both House and Senate. All Congressional Committees therefore will have higher proportions of Democrats.

In the Senate the ratio of Democrats to Republicans increased from 49 to 47 in the 85th Congress to 62 to 34 in the new one. Committee composition may run as much as 10 to 5 or 9 to 6 in favor of the Democrats.

In the House, where there were 233 Democrats and 200 Republicans in the last Congress, the ratio has changed to 283 Democrats to 153 Republicans.

In the Senate there will be 18 Senators serving for the first time, 15 Democrats and three Republicans. There will be 82 first-term members of the House, 63 of them Democrats.

Changes In Ohio Delegation

Democrats gained three Congressional seats in Ohio: Robert W. Levering, replacing the late J. Harry McGregor in the 17th District; Walter H. Moeller who will succeed Thomas A. Jenkins, who retired, in the 10th District; and Robert E. Cook, who defeated incumbent David S. Dennison in the 11th District.

There will be two new Republican Congressmen from Ohio: Samuel L. Devine, who succeeds John

M. Vorys, in the 12th District, and Delbert L. Latta, who replaces Cliff Clevenger in the Fifth District. Messrs. Vorys and Clevenger, both Republicans, did not seek re-election.

In Ohio's Congressional delegation there will be 14 Republicans and nine Democrats, as compared with 17 Republicans and six Democrats last session.

Stephen M. Young, a Democrat, will succeed the defeated incumbent John W. Bricker, a Republican, as one of Ohio's two U. S. Senators. The other Senate seat is held by Frank J. Lausche, a Democrat.

Anticipated Federal Proposals

On the basis of developments last session, and the known interests of many of the new members of the National Senate and House, here are the health areas where intensive activity is assured.

Social Security

Labor has announced that it will work this year for substantial changes in social security, the most important being a program for hospital-nursing home care for the aged and other beneficiaries. On this the unions are supported by the Democratic Advisory Council, which reflects the views of the Truman-Stevenson-Butler element of the party but generally finds itself to the left of Senate Leader Johnson, House Speaker Rayburn and some other Congressional leaders.

Under social security, the AFL-CIO and the Democratic Council also would lower or drop the age 50 requirement for disability payments, increase the OASI taxes, bring more income under the taxes, and raise benefits all up and down the line.

American Medical Association, joined by scores of other associations and individuals in health and other activities, successfully opposed the social security hospitalization plan last session. They are prepared to wage just as determined a fight this year.

Aid to Medical Schools

An effort was made in Congress last session to provide grants to medical schools for building and equipping teaching facilities, to complement the research grants program already in effect. While the administration supported the attempt, it did not throw behind it all the energy it is expected to exert this year.

Top officials of the Department of Health, Education, and Welfare, from Secretary Flemming on down, have been talking up aid to medical schools all fall. When time comes to testify, they will be strengthened by the activities of a new committee appointed to look into the school's problems, as

well as by the Bayne-Jones report which calls for the immediate start on construction of between 14 and 20 medical schools.

American Medical Association supports construction and equipment grants for medical teaching facilities. Strongest opposition this year is likely to come from some influential members of Congress, who succeeded in bottling up the legislation last session.

The Keogh Bill

Last session this legislation to permit the self-employed to pay taxes on money withdrawn from retirement funds passed the House but failed to get out of committee in the Senate. Its sponsors, including the AMA, are hopeful that the Senate objections can be removed this year.

Medicare

Congressmen already have received protests from back home about restrictions imposed on the civilian phase of Medicare, mostly the channeling of service families to military facilities. This issue is sure to come up when appropriations hearings start on the Defense Department's budget. It may come up sooner, if Medicare runs out of money and requires a deficiency appropriation.

The Doctor Draft

The special draft, which hasn't actually been used in two years, may be invoked by the Defense Department this spring, if there isn't a better response on the part of interns and residents to the appeals for volunteers. Should the law have to be used this year, the Defense Department will have a pretty convincing argument that it should be extended beyond its scheduled expiration date of next June 30.

Medical Research

While the Federal government currently is spending at a rate of more than \$324 million on medical research through the National Institutes of Health, a still higher record of appropriations is in prospect for next year. The Senate Appropriations Committee has announced that never again will the pace of research be slowed through lack of dollars. This is also the attitude of the AFL-CIO and the Democratic Advisory Council, among other groups. The pattern usually is for the House to increase moderately Budget Bureau figures for medical research, then for the Senate to vote large additional increases. The House then generally agrees to spend close to what the Senate wants.

Federal Workers

A new effort to bring about a contributory health insurance program for civilian federal workers is

expected, with federal employee unions leading the drive.

Other Prospects

A number of amendments will be proposed for the Hill-Burton act. Some effort will be made to strengthen the law under which labor-management health and welfare funds must keep records and file reports. Hospitals are looking forward to low-cost loans under a community facilities bill and nursing homes to mortgage guarantees. The feud over VA's closing of 5,000 beds likely will be renewed.

Legislative Objectives For 1959 Disclosed by Ohio AFL-CIO

The AFL-CIO in Ohio has announced it will seek to have the 103rd General Assembly enact a 13-point legislative program including a full employment act, a state income tax, increased unemployment and workmen's compensation benefits, a higher minimum wage, and a Department of Labor with general jurisdiction over all general labor matters. The labor legislative program also includes these other objectives:

Taxation—Repeal of the state sales tax and other state and municipal excise taxes and substitution of a state income tax patterned after the federal system.

Unemployment Compensation — Immediate authorization for supplemental unemployment benefits; raise unemployment benefits to equal 75 per cent of average weekly wages; increase benefits from the present 26 weeks to 39 weeks.

Aid to the Aged—Financial aid to the aged should either be drastically increased from the present \$65 a month maximum or the maximum eliminated entirely and each recipient of aid be judged on the basis of specified need.

Public Housing—Revise the \$2400 maximum income limit for admission to public housing projects to allow additional moderate income families to occupy dwellings under jurisdiction of metropolitan housing authorities.

Farmers — Eliminate farm tenancy; improve rural fire protection; stimulate farm cooperatives; extend health facilities and expand electrification to more rural areas.

Public Employees—Enact legislation to provide grievance procedure, mediation, and voluntary arbitration for those under civil service; permissive legislation to allow public employees to have social security.

Election Laws—The General Assembly should make it mandatory for boards of elections to provide precinct registration facilities; voting hours should be expanded.

Federal Medical Spending . . .

Breakdown by Washington Office of AMA Shows Massive Scale of Expenditures for Fiscal Year 1959; Another New High Anticipated

THE Federal Government's medical activities are on a massive scale and they continue to grow. In the accompanying tables will be found tabulations of government finances in the medical field, prepared by the Washington Office of the American Medical Association.

In the current fiscal year for all health programs (research, medical care, public health) Uncle Sam is spending about 62.6 per cent more than he did five years ago, 13.5 per cent more than last year. Programs in 22 separate agencies and departments of Government range from cancer research to federal employee clinics. The total cost is \$2.8 billion, or \$344.7 million more than last year. Right now the agencies and the Bureau of the Budget are working on requests to be presented to the new Congress. There is little question that the bills, when finally enacted for fiscal year 1960, will set another new high for medical spending.

For six years now the Washington Office of the American Medical Association, through an annual budget report, has charted this expanding course of federal medical activity, a service not performed by any other organization. The report identifies all programs, describes their purpose, gives their

present appropriations, and notes the amount of increase. No attempt is made to evaluate them—to rate them as good, bad, or indifferent; as wasteful or invaluable. It is a factual study, based on scrutiny of appropriation acts passed by the last Congress and information supplied by program and fiscal officers in the various departments and agencies. This one covers the current fiscal year which ends next June 30.

While nearly 38 million people are eligible to receive all or part of their medical care from or through the Federal Government, medical care represents only a part of the total spent by the U. S. in medical fields. Many millions of dollars go for research, drug control, personnel training and other efforts not directly related to the rendition of medical care.

As in last year's report, the report lists in table form payments to disabled persons through programs which the Federal Government finances entirely or in part. Such beneficiaries now total nearly 6,000,000, a 15 per cent increase over last year. Money paid them has increased to \$4.75 billion, over 40 per cent more than last year. These data are separated from the rest of the report because not all of the money is Federal. (Page 89).

MEDICAL-HEALTH BUDGETS OF FEDERAL DEPARTMENTS, AGENCIES AND COMMISSIONS FOR THIS FISCAL YEAR

Agency	Fiscal 1959	Fiscal 1958
Department of Health, Education, and Welfare	\$1,116,207,806	\$849,395,800
Veterans Administration	843,524,000	849,374,000
Department of Defense	751,115,000	702,305,000
Atomic Energy Commission	45,462,000	40,085,000
International Cooperation Administration	39,600,000	37,300,000
Department of State	21,638,380	15,718,110
National Science Foundation	19,575,000	7,500,000
Office of Civil and Defense Mobilization	13,617,000	3,177,000*
Federal Employees Health Programs	11,000,000	10,000,000
Department of Labor	8,827,000	8,069,476
Panama Canal Co. and Panama Canal Zone Government	3,959,900	5,988,300
Department of Treasury	3,854,500	3,837,850
Department of Justice	2,105,000	1,796,000
District of Columbia	2,000,000	3,700,000
Federal Trade Commission	1,600,000	1,500,000
Department of Commerce	1,212,400	911,300
Civil Service Commission	426,000	387,000
President's Comm. for Employ. of the Physically Handicapped..	214,700	182,575
Small Business Administration	150,000	70,000
Department of the Interior	140,000	154,950
National Advisory Committee to Selective Service	19,000	19,000
Office of the Attending Physician of Congress	13,145	12,145
TOTALS	\$2,886,260,831	\$2,541,483,506

* The figure for fiscal 1958 is the appropriations of the Federal Civil Defense Administration and the Office of Defense Mobilization; now combined in the Office of Civil and Defense Mobilization.

**PAYMENTS TO INDIVIDUALS BECAUSE OF DISABILITY THROUGH PROGRAMS IN WHICH
THE U. S. GOVERNMENT PARTICIPATES (fiscal year ending June 30, 1959)**

(Small groups of federal retirees' plans not listed; administrative cost of program omitted)

Programs	Estimated Beneficiaries	Approx. Payments
Veterans Benefits		
A. Service-Connected Disability	2,445,000 ^a	\$2,013,000,000 ^a
B. Non-Service-Connected Disabilities	1,332,000 ^b	1,135,000,000 ^b
Military Retirement Permanent & Temporary Disability	82,600	221,840,000
Federal Employees Compensation (Payments)	136,500	24,835,000
(These programs fully financed by U. S.)		
Public Assistance		
A. Aid to Needy Permanently & Totally Disabled	336,000	260,200,000 ^c
B. Dependent Children Aid (incapacitated father segment)	722,000 ^d	235,000,000 ^d
C. Aid to the Blind	108,800	90,400,000 ^e
Disability Annuity Payments to Civil Service Retirees	90,000 ^f	127,000,000
(Public Assistance financed 55% U.S. & 45% states; Civil Service financed 50% U.S. & 50% employees.)		
Social Security — OASI Disability		
A. Disability Over Age 50	262,000 ^g	333,000,000
B. Childhood Disability Benefits ^h	52,000 ^h	24,000,000
C. Dependents of Disabled Workers ⁱ	80,000 ⁱ	50,000,000
(These programs financed by OASI Payroll Tax)		
Railroad Retirement Disability		
A. Permanent Disability for Regular Job	30,000	42,000,000
B. Permanent Disability for All Employment	71,000	88,000,000
C. Temporary Disability	150,000	50,000,000
(These programs financed 50% employers - 50% employees.)		
Total.....	5,897,900^j	\$4,694,275,000

^a 388,000 dependents in this total; program decreasing as beneficiaries die.

^b 511,000 dependents in this total; program is increasing rapidly.

^c \$143.9 million of this total is provided from U. S. funds. Additional program administrative cost is about \$29.8 million (11.5%); U. S. share is \$14.9 million.

^d Provided to 167,000 families. \$142.8 million of benefits is federal. Additional administrative cost is \$22.8 million (9.7%); U. S. share is \$11.4 million.

^e U. S. contribution to program is \$45.4 million. Additional administrative cost is \$6.6 million (7.3%); U. S. share is \$3.3 million.

^f Number of persons in this program increased by 11,400 over last year.

^g 262,000 beneficiaries are estimated at mid-year; by July 1, 1959 estimate is 330,000.

^h Eligibility based on disability incurred before age 18; the 52,000 beneficiaries listed is at mid-year; by July 1, 1959 total will reach 73,000.

ⁱ Does not include any childhood disability beneficiaries entitled to benefits as dependents of disabled workers; the 80,000 beneficiaries listed is at mid-year; by July 1, 1959 total will reach 134,000.

^j No adjustment made for payments to one individual through more than one program.

Report Shows Results of First World-Wide Medical Qualification Exams

Results of the first world-wide American Medical Qualification Examination held September 23 in 30 U. S. examination centers and 30 foreign centers have been announced by Dr. Dean F. Smiley, executive director, Educational Council for Foreign Medical Graduates.

The foreign centers were established in Latin America, the Far East, the Middle East and Europe.

Statistics reveal that of the 844 foreign-trained physicians taking the examination, 418 passed and will receive the ECFMG Certificate. According to the council, these physicians are certified as possessing medical knowledge reasonably equivalent to that expected of graduates of approved American and Canadian medical schools and as having satisfactory facility in the English language.

The examination results also indicate that 226

candidates came sufficiently close to passing, in spite of language difficulties, to earn temporary certificates which will qualify them to study not more than two years as interns or residents in U. S. hospitals approved for internship or residency training.

Those foreign-trained physicians who pass the examination and enter the U. S. on exchange visitor visas may participate in the National Intern Matching Program or apply directly to a hospital for an internship or residency, Dr. Smiley explained.

He also pointed out that graduates entering the U. S. on immigrant visas may be admitted to licensing examinations in at least 16 states.

He added that a number of the medical specialty boards in the U. S. will accept certification by the ECFMG as satisfying their requirements that candidates for their certifying examinations are graduates of approved schools of medicine.

Medical Ethics . . .

Basic Code of the Profession Is Discussed by President-Elect Mayfield Before Students at the Fall Convocation of the OSU College of Medicine

ON last September 29, Dr. Frank H. Mayfield, Cincinnati, president-elect of the Ohio State Medical Association, addressed the Convocation Exercises of the Ohio State University College of Medicine on the subject, "Medical Ethics." The text of Dr. Mayfield's talk follows:

* * *

I extend special greetings and welcome to the first year classes as their members undertake to prepare themselves to enter this most ancient of the professions—a profession whose greatest glory rests in the frequency with which intellectual achievement is joined with character and eminence in human relations in its members.

It is a great honor to be invited to address this convocation as you begin the celebration of your 125th anniversary, and I hasten to extend to you all the most cordial greetings and felicitations of the Ohio State Medical Association and of the University of Cincinnati.

Before accepting this invitation, however, I wondered for a time about a subject—a subject, that is, upon which my knowledge and experience would be sufficient to compliment this occasion. Under these circumstances, perhaps you are surprised that I have the effrontery to speak upon the subject of ethics, but it seemed particularly appropriate to me that the basic code which distinguishes us as a profession be discussed in this assembly.

Cites Misunderstanding

For several years it has been my privileged responsibility to sit in the councils of several medical organizations and also the Board of Directors of the University of Cincinnati, where controversies involving doctors and/or teachers in matters of ethics are heard.

From the experiences gained in these councils, it has been apparent that there is a substantial misunderstanding among doctors, including some who are also teachers, as well as among patients, as to what part of the so-called Principles of Ethics, as published by the American Medical Association, is in fact ethics and what part is etiquette or rules of conduct—or simply questions of good manners or good taste.

I do not possess the scholarship, and this is not the place to discuss the history of ethics. It is necessary, however, to point out that, while our

rules of conduct are based in most instances on fundamental ethical principles, they are not the origin of ethics in general nor of medicine in particular, nor did the science of ethics derive from the work of Percival in 1803, from which these rules were drawn.

Beginning of Ethics

No, the science of ethics arose in the so-called Golden Era of Greece, when the foundation of philosophic thought was being laid. Ethical principles formed the central theme of philosophy—a philosophy which recognized four kinds of goodness, now called the cardinal virtues. They are: Wisdom, Justice, Courage and Temperance.

It was in this cradle that the code of medical ethics was born. It is a code which in general holds that human life and dignity are the supreme values of the universe and that the individual is entitled to justice and to freedom—freedom of person, of religion, of thought and speech and also, I insist, freedom to choose his own physician.

Has Been Inspirational

It is a code which holds that we are a profession practicing the art of medicine, a profession dedicated to the service of humanity, and that we are pledged to care for the individual regardless of our personal comfort or safety and that material reward is of secondary importance.

This simple code has inspired the medical profession since that time. Some hold that it is too idealistic or impossible of human attainment. It is true that the ideals of the medical code of ethics never have been truly realized. It is true also that the ideals of the Constitution of the United States never have been fully achieved, but I believe that George Washington's most pertinent observations in reference to the Constitution were those in which he said, "If, to please the people, we offer what we ourselves disapprove, how can we afterwards defend our work? Let us raise a standard to which the wise and honest can repair. The rest is in the hands of God." The code of medical ethics is truly a standard to which the wise and honest can repair.

Has Served as a Test

The Greek physician, and all medical scholars since, have sought to build upon these simple prin-

ciples a high "esprit de corps," with a tradition of noble bearing and wholesome personal honor in medical practice. To the extent that these traditions have been upheld, the closing prayer of the Oath of Hippocrates, which asks, "Now if I keep this oath and break it not, may I enjoy honor in my life and art among all men for all time," has been granted, for to the extent that the physician advances the endless fight against disease and in proportion to his professional skill and that vague trait which Joyce has described as the gift of certitude, they become renowned, honored and beloved by their fellow men—and occasionally well-to-do. However, insofar as they have transgressed or foresworn themselves, the opposite has befallen them, as in Rome when the Emperor, by decree, made them vassals of the State, "since they no longer cared for the sick but grovelled instead before the rich."

Periods of Transition

The transition from this simple code which guided the Greeks to the rather complicated set of rules, recently revised, which now guides us began perhaps with the writing of the Oath of Hippocrates, but the transition was completed, for all practical purposes, in England in 1803 by Sir Thomas Percival.

It was inevitable, I suppose, that this effort to establish detailed rules to guide the physician in all of his variable dealings with his fellows, with his patients and with the community, even though based on ethical principles, should have led some to follow the letter rather than the spirit of the rule.

Also it was inevitable, I suppose, in view of the great and variable number of conditions which had to be considered, that conflicts of semantics should creep in to provide a verbal screen behind which the unscrupulous might seek to hide. These conflicts led to modifications of this code before it was adopted by the American Medical Association in 1847, and it has been revised several times since, most recently in 1958, yet the confusion and misunderstanding has not been erased.

Must Be Taught By Example

An effort has been made to separate the simple code of ethics, with an explanation thereof, from rules of etiquette. It also has been proposed that ethics be included in the curriculum of medical schools. These proposals appear to me to have little merit, for the ethical physician requires no rules to make him honorable or honest or courteous, and no rules will hold an unethical one except those that are enforced by the whip. Furthermore, ethics is not a subject which can be conveyed to a

student by a lecture. It is a way of life. It always has been and always must be taught by precept and example by every member of the faculty and every practitioner every day.

As recently as twenty-five years ago, when classes were smaller and the curricula limited, most upper classmen in particular came in long and intimate contact with great teachers, who were also great clinicians. In addition to having their minds and hands trained by these men, they came to understand from them the exalted philosophy which is our code.

However, as the scientific curriculum has expanded and more of the teachers' time is devoted to graduate education and research, there is less opportunity for the student to spend long hours under their preceptorship. Instead the students obtain their education in shorter sessions from a greater number of teachers.

This is not criticism of our schools; it is recognition of a trend. However, if students must be more widely separated from the faculty heads, far greater responsibility falls upon the other members of the faculty.

Mission of Medical Schools

Somehow, I cannot leave this subject without diverging for a moment to give my personal opinion about the mission of medical schools. A medical school must provide training for undergraduates and also for graduates and an atmosphere and facilities that will encourage research, yet its primary mission is to teach students how to practice the art and the science of medicine.

I hope that this faculty will promote the philosophy that the general practice of medicine is the highest achievement to which the student may aspire, leaving to specialize or to engage in basic research those who have such unusual talent that they show promise of advancing the scientific phase of medicine or, as in the case of some of us, such limited talent that they are unable to develop the broad skills necessary in general clinical practice.

Please do not infer from this any lack of interest in or appreciation of those who engage in basic research. Indeed, my feeling for the true scientist who is driven only by an unquenchable thirst for truth is one of reverence, but the pseudo-scientist whose motivation is the desire for notoriety leaves me cold.

I am sure that there is no contractual collusion between Nature and those who work in buildings bearing the name Research to reveal her secrets only to them. I would add further that the traits of character and personality that make of one

man a great investigator or that enable another to win renown as a clinician are not necessarily the same as those that make of some of them also great teachers, who are able to attract and inspire students.

To me the gifts of a great teacher are the most valuable assets of any school, and this school is richly endowed.

Importance of Humility

My life has been greatly influenced by Dr. G. Paul LaRocque, Professor of surgery at the Medical College of Virginia. His first remark to us as sophomores was, "If there is any man here who does not consider it just as noble to take out a bedpan as to take out an appendix, he might as well drop out now." These words never have let me forget the importance of humility.

To return to my subject of medical ethics and medical etiquette, let me emphasize that the underlying principles of ethics never vary, but rules of conduct change with the times and with social conditions. The premise that human life and dignity are the supreme values of the universe never must be questioned. In those segments of society where the pledge not to give poisons has been compromised in the interest of euthanasia gas chambers such as in Buchenwald have followed. No doubt you will be called upon from time to time to care for individuals to whom your judgment suggests that death would be less painful than life. Put such thoughts from your mind. We are not the authorized executioners.

Freedom and Justice

Bearing closely upon this principle of the sanctity of human life is the premise that the individual is entitled also to freedom and justice. The value of close personal ties between physician and patient has been recognized since the days of Babylon, 2700 years before Christ. It is equally valid today. The patient must have absolute confidence in the physician's ability, his integrity and discretion before he can be led to reveal the most confidential matters about himself which are so essential in diagnosis and treatment. This is the origin of the privileged communication.

This also relates to the restraint which is placed upon advertising and the solicitation of patients, though the latter evolves more directly from the fact that the sick, through fear, are rendered vulnerable to any nostrum, however unsound, offered by the charlatan, and since the ethical physician holds no secret from his brother, solicitation of patients cannot be justified. Many individuals, including some representatives of the

press, have thought that this was a self-imposed rule designed to limit competition, but this is, in no sense, its purpose.

Ethics In Third Party Plans

It has been argued that the introduction of a third party, such as an insurance carrier, between the physician and his patient involves unethical principles. When a patient purchases insurance, he contracts to provide the carrier with information relative to the carrier's obligation. Therefore, the privileged communication in this instance is not binding.

Since the issue of third party influence on the practice of medicine is under debate in many circles at this time, I will omit it from this discussion except to say that the ultimate determination as to whether it is ethical or unethical will be determined by its influence upon patient care and not the economic status of the physician or the third party.

Consultations

When one accepts the bounty of charity and enters a hospital, he usually cannot retain the right to choose his own physician. This is true of your Ohio State University Hospital. This is true also of our Cincinnati General Hospital.

However, the oath of Hippocrates and the Principles of Ethics of the American Medical Association hold that a consultation must and should be sought either when the physician is in doubt or the patient desires it. At times the patient will desire consultation with his family physician, yet the family physician may not be on the faculty. What should you of the faculty and the house staff do in such an occasion?

In my opinion, you should call the consultant desired and treat him with every courtesy—that is, unless you consider him either incompetent or immoral, and if perchance you should feel that way about many, then you of the faculty ought to resign, for you have taught them. If individuals complete their medical education here and are found incompetent or immoral, either you have chosen them improperly or have trained them improperly. Actually, of course, neither of these conditions prevails. The overwhelming majority of the practitioners of this community and the faculty are most competent and honorable men.

Transfer of Proper Information

The rule of ethics which requires that you not accept the responsibility for a patient who is under another physician's care without conferring with him, was not established in order to protect that physician's practice. It was established in order

to insure the transferral of proper information and the continuation of treatment.

This problem of consultants is not confined to hospitals affiliated with medical schools. Rudeness emanating from misunderstandings about who has the privilege to do what in which hospitals has created more discord among doctors and more work for the committees on which I serve than any other problem which confronts them, yet the problem is not new.

Percival in his original code wrote, "The choice of physician or surgeon cannot be allowed to hospital patients, yet personal confidence is not less important to the sick poor than to the rich, and it would be equally just and humane to call in consultation the favorite practitioner. The rectitude and wisdom of this conduct will be more apparent when it is recollected that patients not infrequently request their discharge on a deceitful plea of having received relief, and afterwards procure another recommendation that they may be admitted under a physician or surgeon of their choice."

Obligation To Teachers

Many of this audience are bound not only by the ethics of the medical profession but by those of the teaching profession as well, so perhaps it would be in order to discuss for a moment the matter of pay for medical teachers, as stated in the oath of Hippocrates. In this section, one swears, "To regard my teacher as my parent, to make him partner in my livelihood, and when he is in need of money, to share mine with him."

The recognition of this obligation and its partial fulfillment is exemplified here in the alumni fund. It is well perhaps to keep in mind that there is a direct relationship between the generosity of the donor and the goodwill he holds for his teachers.

The oath requires further on "To teach them this art that requires to learn it without fee or indenture." Does this imply that it is unethical for teachers to receive pay for their administrative duties? The answer, of course, is no. It is obvious that this section of the oath and that having to do with secret remedies and inventions arises from the conviction that the health and welfare of the individual transcend in importance all normal business considerations. Therefore, we have pledged ourselves not to withhold from others for purposes of financial profit any information and/or therapeutic agent.

It obviously is also unfair to insist upon the right of the patient to choose his physician and

at the same time deny him the right to choose one who is on the faculty, though this has been tried in certain areas. Furthermore, I would ask, "How can one teach the art of the practice of medicine unless he also practices it?"

Principle of Justice

This brings us again to one of the fundamental ethical principles, namely Justice. The fundamental philosophy of the Constitution of the United States holds that justice is based on law and not arbitrary exercise of power. The phrase "We the people . . . to establish justice . . ." leaves no doubt as to its intent.

In democracy, partisan debate is necessary in order that truth be known, but justice demands that the power of decision lies in the hands of impartial tribunals. Therein lies the justification of our Supreme Court.

As a child, I saw this philosophy work at our family table. The selfish desire of my brother and me for the largest piece of pie was solved by my mother, who required that one of us cut the pie and the other have the first choice. It was surprising how perfectly we, as kids, without knowledge of academic formula, could equate a circle under these circumstances.

We of the medical profession have been accused of protecting delinquent physicians, and perhaps with some justification, but we are bound by oath and principle to expose our colleagues for incompetent or dishonorable practice. It would prolong this discussion unduly and perhaps cause you to miss important classes if I undertook to debate this matter in detail. I believe, however, that when the legal profession truly seeks justice rather than judgment, these matters will be resolved.

Evil of Gossip

The admonition not to speak ill of another physician except before a proper tribunal is sound. Recently it was discovered that the turbulence created by crossing ultrasonic waves could be used to destroy tissue. This should have surprised no one, for the cross-currents of lower frequency in the form of gossip have damaged the body politic for centuries.

The distinction between matters of good taste and bad taste and good manners and bad manners does not lend itself to definition. Just why I can enjoy jokes that I tell about my own religion yet be offended when another expounds them, or why people are amused by stories whose punch line refers to the bedroom but consider bathroom stories rude, I do not know, but I would like to

recount two incidents involving one intern that point up the distinction in medical matters.

Good Taste and Bad Taste

In 1933, while I was assisting Doctor Bigger, the Professor of Surgery at the Medical College of Virginia, an aneurysm of the innominate artery was exposed. It appeared at any moment that this restless rope might explode. Anesthesia in those days was not well advanced, and the whole situation was tense. The surgeon asked the intern in passing if he thought the aneurysm should be wired, a technique which was then in vogue. The intern replied, "I don't know, sir, but I think we should wire the family." This frank acknowledgment of the danger that confronted us brought laughter and broke the tension.

This boy, at a later date, was severely disciplined when he closed certain charts with the final diagnosis, "P. M. S." When asked by the librarian what these letters meant, he said, "Poor, miserable S. O. B." Just as I prefer that you not make callous jokes about my family or religion, both of which are sacred to me, it is improper for you to speak or to think about the most important disease in the world to the patient—namely, his own—in these terms.

This is enough of the do's and don'ts of medical ethics and medical etiquette. There are no snares awaiting in the rules of ethics and etiquette to entrap the ethical physician. If you practice your art with honor, only respect from your fellows will come to you.

Medicine—"Queen of The Arts"

In closing, if I may paraphrase Mr. Lincoln, I would state that it matters little what I say here, and it matters little what you have done so far, unless you dedicate yourselves now to the noble traditions of Medicine, but if you so dedicate yourselves and prepare yourselves, a glorious way of life awaits you, including some of the creature comforts.

To prepare yourselves, it is necessary among other things that you acquire what Osler called equanimity, or, as my friend Dr. James Klumpp has described it, that you learn early the price of glory, lest the price of it first come to your attention in the cold, clammy confines of an oxygen tent.

The practice of Medicine is an art; it never can be a true science, but it is truly the Queen of Arts, and I urge you to make her your mistress, for as Enobarbus said of the glamorous Cleopatra, "Time will not wither her, nor custom stale her infinite variety."

Rail Firemen-Enginemen Set Up New Medical-Hospital Plan

The following article about a nationwide hospital and medical care program for members of the Brotherhood of Locomotive Firemen and Enginemen appeared in the *Cleveland Plain Dealer* on December 10:

The Brotherhood of Locomotive Firemen and Enginemen last night announced inauguration of a nationwide health security program for an estimated 65,000 members and their dependents.

Announcement of the start of the program after months of careful planning and study was made from the union's international headquarters here by H. E. Gilbert, president.

First to enroll for the special health coverage were BLF&E members on the Kansas City Terminal Railway. Plans provide, Gilbert said, for initiation of the program on a railroad-by-railroad basis, except for large properties where separate general grievance committees are maintained.

Carriers next in line on the program schedule include the Nickel Plate Road; Indiana Harbor Belt; Cleveland, Cincinnati, Chicago & St. Louis Railroad; Interstate Railroad; and the Great Bay & Western Railroad.

Gilbert said the BLF&E sought to answer the pressing demand for adequate health coverage through its own program and using the nationwide facilities of the Blue Cross and Blue Shield organizations.

The brotherhood's plan, he said, parallels, to a certain degree, the regular Blue Cross-Blue Shield coverage in many communities.

Members will finance the program. In explaining the union's group insurance program, Gilbert cited what he termed "important differences" that make it "far superior to regular coverage."

He listed the differences as:

Hospitalization coverage for 365 days with full cost of semi-private room accommodations.

Medical coverage of best available Blue Shield local plan, with 365-day coverage where practical.

No restrictions on preexisting conditions and no waiting period for maternity benefits for those who enroll at the first opportunity.

Hospital Association members can enroll for dependents only if member wishes to retain hospital association coverage.

Widows and dependents of deceased members can transfer to local Blue Cross-Blue Shield plan.

Retirees do not lose coverage on retirement. They remain part of the BLF&E plan and retain benefits at same rates.

Facts and Policies About Annual Dues . . .

Amount of Dues; Date Due; Payable to Whom? Those Exempt From Payment; Data on AMA Dues and Exemptions; Getting Journals

HERE are some important facts and reminders regarding 1959 membership dues. It is vital for each physician to keep his membership in the State Association, his county Medical Society, and the AMA up to date. Those who have not paid 1959 dues should get in touch with their County Society secretary-treasurer immediately.

Amount of Dues: State Association, \$25.00 or \$7.50 in the case of interns and residents; AMA, \$25.00; County Society, amount varies from county to county—See your local secretary-treasurer.

Membership and Dues for Residents and Interns: A physician serving a hospital internship or residency within a period of five years following graduation from the medical school (excluding time in military service), who becomes a member of a county medical society and meets the membership eligibility requirements of the OSMA By-Laws, does not have to pay full state dues for 1959. By official action of The Council September 12-14, 1958, state dues for such members were set for 1959 at \$7.50. Such members will not receive *The Journal* automatically but may subscribe to *The Journal* at one-half the regular rate—namely for \$2.50.

So far as AMA membership is concerned, the AMA By-Laws provide that it may excuse from the payment of AMA dues, interns and residents during the first five years following graduation from medical school (excepting military service) provided their local and state dues are fully or partially waived. Therefore, intern and resident members in Ohio who are assessed the partial dues (\$7.50) will be entitled to AMA membership without payment of AMA dues. However, in order to receive the *AMA Journal* or some other AMA publication, they will have to purchase a regular subscription from the AMA.

Date Dues are Due: On or before January 1, 1959. Membership is on a calendar year basis.

Dues Payable to Whom? Secretary-treasurer of County Medical Society. When paying dues to him, send check for total amount of local, State and AMA dues. Maintaining membership in the AMA is optional, but the large majority of Ohio physicians belong to the AMA. Don't send dues direct to Columbus Office—pay them to local secretary-treasurer.

Who is Exempt From State Dues? There are only two classes of members of the OSMA who are exempt from the payment of state dues, namely:

(a) **Military Members:** Members of the OSMA on extended active duty in the military service or U. S. Public Health Service but who are not making military medicine or public health work a career, are entitled to **exemption from OSMA membership dues** while they are in the service. Dues paid by a member before entering the service will not be refunded, but dues will be waived if he enters the service prior to paying dues. Certification from local secretaries will be necessary in all such cases.

(b) **Aged or Disabled Members:** A member who **retires**, or has been retired, from active practice because of **age or disability** and who was in good standing at the time of retirement is exempt from the payment of State dues, **providing he requests such exemption and such request is approved in writing by the secretary-treasurer of his county medical society.**

Remember: The determining factor is not how old the physician is but whether he has retired from active practice.

Who Is Exempt From AMA Dues?: The following physicians, who are members of the OSMA either through payment of OSMA dues or by exemption of OSMA dues, can carry membership in the AMA without paying AMA dues:

(a) **Military Members:** OSMA members in temporary military service prior to January 1, 1959, are entitled to AMA membership **without payment of dues.** Members entering military service prior to July 1, 1959, will owe AMA membership dues of \$12.50—one-half year; those entering military service after July 1, 1959, will owe dues for the entire year—\$25.00. Military members for whom AMA dues are waived and who desire to receive *The AMA Journal* while in the service may do so by buying, directly from the AMA, an annual subscription in the amount of \$15.00. The *OSMA Journal* is sent to such members without charge.

(b) **Aged and Disabled Members:** OSMA members who are exempt from payment of OSMA dues because of retirement from active practice due to **age or disability** are entitled to AMA membership without payment of AMA dues. The

names of such members will be certified automatically to the AMA annually by the Columbus Office after their names are entered on the OSMA roster as dues-exempt members for the current year.

(c) **Members 70 years of age:** Members of the OSMA, after attaining the age of 70 years, will be eligible for membership in the AMA without paying AMA dues, starting on January 1 following such member's 70th birthday, providing such member requests such exemption. Such members should file their request for AMA exemption with the Columbus Office after they have received their OSMA membership card for 1959, or any subsequent current year. The Columbus Office will certify their names to the AMA. This AMA exemption will be automatic year by year, providing the physician's name is carried on the membership roster of the OSMA, either as a dues-paying member or as a retired member. To get the *AMA Journal* these 70-year old members must purchase a subscription.

(d) Members of the OSMA who are serving an internship or residency during the first five years following graduation from medical school (excluding time in military service). This is because their dues are partially waived by the OSMA (they pay only \$7.50 to OSMA). Those in post-graduate training after the five-year period are not excluded from paying AMA dues.

Those not exempt from OSMA dues: The following are not exempt from the payment of OSMA dues, either \$25.00 or \$7.50:

(a) **Members in practice or in internship or residency training.** As mentioned previously, those in internship or residency during the first five years following graduation from medical school (excluding time in military service) are assessed dues of \$7.50—not \$25.00 the dues of other classes of paying members.

(b) **Regular commissioned medical officers of the Army, Navy, Air Force, or U. S. Public Health Service, and permanent medical officers of the Veterans Service and the Indian Service are NOT exempt from OSMA dues.** If they desire to be members of the OSMA, they must qualify the same as civilian physicians and pay current dues. However, physicians of these classes are eligible to apply for **Service Membership** in the AMA, and if accepted into Service Membership, will not be required to pay AMA dues.

Send Change of Address Promptly: Occasionally a new member wonders why he does not receive the OSMA and AMA journals at once. The answer is simple. It takes the OSMA Columbus Office about four weeks to get a new

stencil made and the mailing list adjusted to take care of mailings to new members. It takes the AMA longer because of its very large mailing list. Also, some months extra copies of the journals are quickly exhausted. Moreover, the Post Office Department frequently causes the delay in delivery especially if the office does not have the member's street number, office room number and zone number. The Columbus Office makes a real effort to send out OSMA journals to new members by special handling but that can't always be expedited. If a new member fails to get the magazine on two consecutive months, something is wrong and he should notify the Columbus Office. All members can help the Columbus Office in keeping the mailing list up to date by sending in changes of address promptly.

Journals: State Association members, who pay full dues or are exempt from payment of any dues, receive *The Ohio State Medical Journal* as a part of their membership privileges—no extra charge for *OSMA Journal*. Those who pay dues to AMA receive the *Journal of the AMA* as a part of their membership privileges—no extra charge for *AMA Journal*.

A dues-paying AMA member may secure in lieu of the *AMA Journal*, any other official publication of the AMA on special request by him direct to the AMA at 535 N. Dearborn Street, Chicago. These publications are: *Archives of Internal Medicine*, *American Journal of Diseases of Children*, *Archives of Dermatology and Syphilology*, *Archives of Neurology and Psychiatry*, *Archives of Pathology*, *Archives of Surgery*, *Archives of Otolaryngology*, *Archives of Ophthalmology*, and *Archives of Industrial Hygiene and Occupational Medicine*.

Those exempted from payment of AMA dues must place a special subscription for the *AMA Journal* direct to the AMA or any one of the other publications if they desire to receive such publication.

Cincinnati Area GP's

"Pediatrics and the General Physician" was the theme of a recent meeting of the Southwestern Ohio Society of General Physicians. Sponsored in collaboration with the College of Medicine of the University of Cincinnati, the following faculty members participated in the program: Dr. A. A. Weech, moderator; Drs. Harry Shirkey, Daniel Jones, Richard Wolf and Edmond Schweitzer.

The Aero Medical Association, 30th Annual Meeting will be held in the Statler Hotel, Los Angeles, Calif., April 27-29, 1959.

Medical Schools . . .

Annual Report of AMA Medical Education Council Shows 29,473 Students Enrolled in 85 Schools; Ohio Graduated 572 M. D.'s During Past Year

AMERICAN medical colleges had a record enrollment of 29,473 students for the academic year 1957-1958, according to the annual report of the AMA Council on Medical Education and Hospitals. The 90-page report appeared in the November 15, 1958 issue of the *Journal of the AMA*.

In Ohio's three medical colleges, the report shows the following enrollments: University of Cincinnati College of Medicine, 343; Western Reserve University School of Medicine, 325; Ohio State University College of Medicine, 572; a total of 1240.

Sixty of the 85 operating medical schools reported major construction, costing 47 million dollars, in the planning, beginning, or completion stages.

Forty-nine schools reported major developments and changes in administrative organization, methods of student selection, curriculum, and financing.

An estimated 275 million dollars was spent by the medical schools in 1957-58, an increase of 13 per cent over the preceding year.

The report illustrates some of the changes and developments being made in medical schools to meet the changing medical needs of the American people.

It also noted the AMA's continuing support in developing additional facilities for basic medical education. "The increasing population together with various other facets of the shifting [population] pattern obviously indicate the need for constantly increasing the number of physicians," the report said.

This means that existing medical schools must consider expanding their facilities, and institutions of higher education without medical education programs need to give serious consideration to the development of medical programs.

Teaching Methods

Major developments in curriculum and teaching methods were reported at several schools. These include a plan at Duke University to produce physicians who are also skilled medical research scientists; a greater emphasis on education methods for medical teachers at the University of Buffalo, and an experimental program at the University of Pittsburgh whereby medical students may adapt their medical education to one of the specific fields of research, clinical specialties, or general practice.

A section in the report of major developments in curriculum is devoted to the program at Western Reserve activated in 1952.

There are 78 approved four-year medical schools in the United States, along with four two-year schools of basic medical sciences. In addition, three newly developing schools have provisional approval by the AMA council and will be graduating students within the next few years. Ten years ago there were 77 schools, including seven two-year schools of basic medical sciences.

A total of 6,861 physicians was graduated from the 78 schools in 1958, as compared with 6,796 in 1957. The record year for graduates was 1955 with 6,977.

Ohio Graduates 292

Ohio's medical schools graduated the following numbers of M. D.'s last academic year: Cincinnati, 76; Western Reserve, 77; Ohio State, 139; a total of 292.

A new record was established in 1957-58 for the number of entering freshmen—8,030. The preceding year the number was 8,014 and 10 years ago the number was 6,487.

Among the other items the report showed were:

A total of 1,644 women was enrolled in medical school, and 355 were graduated in 1958. Women's Medical College, Philadelphia, enrolls only women, while Dartmouth and Jefferson enroll only men.

Of the 72 schools reporting that the supply of cadavers used for teaching anatomy was probably adequate for the needs of first-year students, 13 reported an insufficient supply for the more advanced students. The other 13 schools reported a "frankly inadequate supply." The report urged more states to give legal recognition to individual bequests of bodies to medical schools.

The American Medical Education Foundation raised \$984,787 from physicians for medical schools in 1957. The National Fund for Medical Education, which receives its money from industry, contributed \$3,078,825 to the medical schools in January 1958.

The median annual cost of medical school to a student, including tuition, minimum board, room, and supplies, in a private institution was \$1,958. In a state-owned school, the cost was \$1,395 to a resident of the state and \$1,731 to a non-resident.

The median amount of money spent by a four-

year school during 1957-58 was between 2.3 and 2.4 million dollars.

The survey of medical schools this year showed that only seven—all state-owned—limited their first year enrollment to residents of the state in which the school was located. This is a drop of five schools from the preceding year.

However, the publicly owned schools had only 4 to 9 per cent of their students from outside the state in which each school was located. As a consequence, the publicly owned schools had only one-fourth to one-fifth as many applicants as did privately owned schools, the report said.

Some Observations

Although the proportion of the total entering classes enrolled in each kind of school was about equal, the number of students lost to medicine by poor scholarship during the first year was significantly larger in each of the past four years in publicly owned schools.

The report said the problem is that their geographic restrictions on residence limit applications by and choice of as many highly capable students on the part of publicly owned schools as are turned away by the geographically non-restrictive privately owned schools.

The report expressed the hope that state legislators and other public officials concerned with these matters will cooperate with university and medical school administrators "in bringing the policies restricting admissions into a more realistic and socially useful focus."

Also included in the report was one by A. J. Carroll, business officer of the State University of New York, which criticizes the "inadequate financial reports" of medical schools. However, the W. K. Kellogg Foundation has made a grant to underwrite a study of medical school financing. It will "be able to prove the financial needs of medical education, and to establish new standards of management efficiency," Carroll said.

The report included extensive information about Canadian medical schools. There are 12 four-year schools, enrolling a total of 3,686 students. They graduated 828 physicians in 1958.

There were 82 United States citizens enrolled in the first medical year in Canadian schools as compared with four Canadians enrolled in the first-year classes of United States schools. The report pointed out that this favorable balance of 78 Americans in the first medical year of Canadian schools represents the "equivalent of another United States school having a class size larger than that of 28 of the United States medical schools."

Course in Ophthalmology Is Offered at Ohio State

A program for postgraduate training in ophthalmology is being offered by the Department of Ophthalmology, Ohio State University on March 2 and 3. The conference will be in the Ohio Union Building on the OSU Campus.

Registration may be made by mail (\$20.00 fee) by writing to: William H. Havener, M. D., Department of Ophthalmology, University Hospital, Columbus 10, Ohio.

The following speakers will be included on the program: Paul A. Chandler, M. D., Boston, Mass.; William H. Havener, M. D., Columbus; Wendell L. Hughes, M. D., Hempstead, L. I., N. Y.; Ralph O. Rychener, M. D., Memphis, Tenn.; Samuel Saslaw, M. D., Columbus. James M. Andrew, M. D., will be moderator.

The program has been announced as follows:

Monday, March 2

- 8:00 Registration
- 9:00 Fundus Pictures of Interest, Dr. Havener
- 10:00 Lacrimal Apparatus, Dr. Rychener
- 11:00 Primary Glaucoma, Dr. Chandler
- 1:00 Management of Eye Injury, Dr. Hughes
- 2:00 Introduction to Staff Members and Their Projects
- 3:00 Modern Antibiotic Usage, Dr. Saslaw
- 4:30 Refreshments at 2070 Northwest Boulevard
- 6:00 Dinner meeting with Columbus Academy of EENT
- 8:00 The Future of Ophthalmology, Dr. Rychener

Tuesday, March 3

- 8:00 Movies—"Save Your Sight," "The Taxpayer," "Case Closed"
- 9:00 Management of Eye Injury, Dr. Hughes
- 10:00 Secondary Glaucoma, Dr. Chandler
- 11:00 Specific Reading Disability, Dr. Rychener
- 1:00 Management of Eye Injury, Dr. Hughes
- 2:00 Congenital Cataracts, Dr. Chandler
- 3:00 Serious Mistakes, Dr. Havener

Obstetrics and Gynecology

The next scheduled examinations (Part II), oral and clinical for all candidates will be conducted at the Edgewater Beach Hotel, Chicago, Illinois, by the entire Board from May 8 through 19, 1959. Formal notice of the exact time of each candidate's examination will be sent him in advance of the examination dates. Details may be obtained from the Office of the Secretary: Robert L. Faulkner, M. D., 2105 Adelbert Road, Cleveland 6, Ohio.

Group Practice . . .

By Full-Time Medical School Teachers and Charging of Fees for Services By Residents Approved in Principle by Recent Action of AAMC Officials

THE following article on actions taken recently by the Executive Board of the Association of American Medical Colleges appeared in the December 1 issue of *Hospitals*, official magazine of the American Hospital Association.

* * *

The executive board of the Association of American Medical Colleges has approved in principle:

Group practice of medicine by full-time clinical teachers in American medical schools.

Support of resident-training programs from funds made available through medical service furnished paying patients by residents in the course of the residents' clinical training.

AAMC's executive board met during the association's 69th annual convention, held Oct. 13-15 in Philadelphia and attended by some 800 medical educators.

Wording To Be Revised

Although the resolutions concerning group practice and funds received for medical care given by residents were approved in principle, the wording of the resolutions was not approved; the resolutions were referred to the AAMC-American Medical Association liaison committee for further discussion.

The tentative resolution on group practice, under study by the liaison committee, states: "the financial plight of many of our medical schools precludes . . . payment of adequate salaries out of university funds [for clinical teachers and investigators]. Since medical service and clinical instruction are interdependent, supplementation of the base salary paid by the university or medical school by fees for medical service is not only logical but necessary."

Resolutions on Group Practice

Group practice by full-time clinical teachers is proper, the resolution under study states, provided:

"Fees are set by the participating physicians.

"Income from fees is deposited in a separate fund or funds in the business office of the university or medical school.

"Disbursements are made in accordance with a plan mutually agreed upon by the university and the faculty members involved.

"The amount of medical service and the number

of physicians providing such service are related to the educational and research requirements of the institution."

The tentative resolution also states that it is not the intention of the resolution to "impose a uniform policy on medical schools or their associated hospitals."

Resolution on Residents

In the second resolution accepted in principle by the AAMC executive board and under study by the AAMC-AMA liaison committee, the resolution concerning fees paid to residents, it is stated: ". . . receipt by qualified residents of financial remuneration from the paying patients when they serve in conjunction with their clinical training is proper provided:

"In the judgment of the physicians directing their education and training, these residents have reached a state of competency adequate for the assumption of appropriate responsibility.

"They possess a license to practice medicine in the state in which is located the institution in which they serve as residents.

"They have the consent of the patients for whose care they assume responsibility.

Fund To Be Established

"Fees received by these residents are deposited in a fund or funds to be used exclusively for the support of resident-training programs. Such fees shall not accrue to the general operating income of a hospital medical school or university.

"The medical service is rendered in the institution where the residency appointment is held and is related to the requirements of a specific resident-training program.

"Fees do not accrue to the individual resident providing the medical service.

"The decision to approve such participation by residents in any given institution must rest with the faculty conducting the training program and the corresponding university administration."

The Board of Trustees of the Cleveland Mental Health Association has named as its executive director, Alexander A. Anderson, for the past five years Administrative Assistant at the Cleveland Society for the Blind.

Facts About Pharmacy and Drugs . . .

Risks and Rewards of Pharmaceutical Research Described In Article in Los Angeles County Medical Society Bulletin; Other Articles To Follow

IN THE LAST two decades the U. S. pharmaceutical industry has played a prominent part in the overthrow of diseases as old as mankind. This accomplishment, symbolized by the "wonder drugs," has given the industry a measure of public attention unknown in the days when medicines were, on the whole, ineffective and innocuous.

The Public's Stake

The public stake in the pharmaceutical industry might be measured by our lengthening life span, or it might be expressed in terms of the conquest of such scourges as pneumonia, tuberculosis, influenza, polio, syphilis, diphtheria, and many others. Perhaps it could better be expressed in the very real hope for equal success over cancer, mental illness, heart disease, arthritis, and other diseases.

The men who guide the pharmaceutical industry are betting that these diseases can be eradicated by new discoveries from their laboratories. But unlike physicians or lawyers, who are paid for their advice whether right or wrong, drug companies profit only from their successes and sometimes not even from these.

How Much Does Company Make?

How much money does a successful pharmaceutical company make? A financial magazine recently tabulated the earnings of seven leading drug firms—Abbott, Lilly, Merck, Pfizer, Smith Kline & French, Schering, and Parke, Davis. Over the five years 1952 through 1956, the average profit of these companies—computed before taxes, interest, depreciation, and certain other items—was 26.2 cents per dollar of sales.

Now compare this figure with four of the largest U. S. corporations—General Motors, du Pont, Standard Oil of New Jersey, and U. S. Steel. On the same basis as above, their pre-tax profit was nearly the same—24.7 cents per dollar of sales.

Highly Competitive

The sheer number of pharmaceutical companies—there are more than 1100 of them—implies another important fact about the industry; namely, its extreme competitiveness. Last year it took in about \$1.6 billion, yet its largest company accounted for only about 12 per cent of that total. By the way of contrast General Motors regularly

Editorial Note:

The accompanying article entitled, "Risks and Rewards of Pharmaceutical Research" appeared in the May 15, 1958, issue of the *Los Angeles County Medical Society Bulletin*. The author was John Weilburg, director, Medical and Pharmaceutical Information Bureau, New York City.

In a series of articles appearing monthly, *The Ohio State Medical Journal* will endeavor to set forth the answers to some of the provocative questions being asked about the pharmacy industry, the costs of drugs, drug research, etc.

The Journal believes physicians should have accurate information on these subjects so they will be able to answer the questions of their patients and, thus, dispel in many instances the misconceptions which people have about the costs of medical care, including the costs of pharmaceuticals.

gets close to half the multi-billion-dollar automobile market.

This fierce competitiveness constitutes one half of the peculiar double risk, almost unique in U. S. industry, that faces the president of a pharmaceutical company when he puts a price tag on a new drug; he cannot know how long it will be before price competition will make his own price totally unrealistic. For example, the price of broad spectrum antibiotics has dropped 65 per cent since 1949, the price of cortisone 90 per cent since 1950. The second half of the risk is that he cannot tell how long his new drug will sell at *any* price—that is, when it will be made obsolete.

Spent \$125-Million on Research in '57

The drug maker can be sure of one thing: his competitors are passionately addicted to making his products obsolete. A measure of that addiction is the estimated \$125 million that the industry spent on research in 1957. This amounts to about eight cents out of every sales dollar, a far higher ratio than any other U. S. civilian industry. In fact, this research budget is quite impressive alongside the industry's profits. If the

entire industry made as good a showing as the seven leading companies, which is unlikely, then the industry's net profit would be about 14½ cents per sales dollar. The industry's research costs would then amount to more than half of the total available for dividends, expansion, and reserves.

Parke, Davis Experience

Let us assume that the drug maker's new product is received by the physician with open arms, and that the research behind the new product is so unique that a swarm of competitive compounds does not immediately appear. Can the manufacturer then sit back and take it easy? Not necessarily, as a recent experience of Parke, Davis demonstrates.

Five years ago, as a result of a medical panic occasioned by misuse of the drug, Parke, Davis suddenly found itself with no American market for its excellent antibiotic 'Chloromycetin.' Within a few months U.S. and Canadian sales dropped from about \$1 million a week to about \$100,000. If an ordinary manufacturer had seen his sales plummet from an annual rate of over \$50 million to less than \$10 million, he would either sell part of his plant or convert it to the manufacture of something else. Neither of these courses was open to Parke, Davis. There are few purchasers for the elaborate facilities needed to produce pharmaceuticals, and the process of discovering and marketing a new pharmaceutical is a long and painstaking one. Parke, Davis hung on in the hope that the panic would abate (it did) and that its equipment would eventually be restored to use (it was). It could well have turned out otherwise.

Irreplaceable Personnel

Another major antibiotics maker told of his company's experience five years ago when the penicillin price wars were eliminating half the major producers of that drug. "We made it at a loss for months," he said, "but we couldn't afford to let those big tanks stand idle and we couldn't stand losing our fermentation personnel. Those fellows had ten years' experience and were literally irreplaceable."

The truth is that a team of top scientists will often be a pharmaceutical company's major asset. Unlike baseball stars, such men cannot be bought. They can develop top performance only in an environment where they will feel free to take a chance on a scientific hunch. Creating that environment costs the pharmaceutical industry eight cents out of every sales dollar.

What About Cost of Drugs?

Why *do* drugs cost so much? Part of the answer is another question: Why does *everything* cost

so much? The official figures merely confirm what every consumer already knows—that everything costs more than it did. Expressed in terms of cost, consumer prices as a whole went up 98 per cent between 1935 and 1956, while the cost of drugs and prescriptions rose only 37 per cent. Expressed in terms of income, Americans in 1939 spent 0.87 per cent of their disposable income for drugs—in 1956 only 0.66 per cent.

But any question about the cost of drugs raises a much more important question: What drugs? In 1935 there were no antibiotics, no sulfa drugs, virtually no steroid hormones. There were no drugs to help the emotionally ill. There were no vaccines for polio, whooping cough, or influenza. So important are these new drugs that seven out of ten prescriptions written by doctors today simply could not have been filled in 1935 because they did not exist.

The New Drugs

The fact that an industry authority has counted some 400 new pharmaceuticals in 1957 does not mean that 400 brand new medicines came out that year. Only 50 were new chemical entities, 88 were duplications of already known agents, and the remainder were new combinations or new dosage forms of existing drugs. (Not that these latter groups are necessarily unimportant; the development of a long-acting penicillin, for example, enabled the gruesome tropical disease known as yaws to be wiped out in Haiti and then in other infested areas.)

Nine of the 50 new chemical entities came from abroad, for U.S. pharmaceutical manufacturers are alert to potential uses for a drug which foreign researchers may develop. But the great number of new pharmaceuticals came from the industry's own research—the kind of research that cost Smith Kline & French Laboratories \$9.4 million in 1957, and occupied about one-quarter of Smith Kline & French's 2700 employees. Large research expenditures are equally common among smaller pharmaceutical houses. For example, Crooks-Barnes Laboratories, a relatively small company, invests ten cents of every sales dollar in research.

"Gold Mine" Theory False

Cases have indeed occurred where a new drug has remade a company, as 'Terramycin,' an antibiotic, enabled Pfizer to convert itself from a maker of chemicals into a predominantly pharmaceutical house in a few short years. But even a revolutionary new drug can fall far short of being a gold mine. Consider the case of isoniazid, which played a major part in closing several major TB

sanitariums and emptied some 3200 hospital beds within two years. Five thousand likely chemicals were synthesized in the search for the drug, and about 1000 of these were tested on animals. Isoniazid was developed independently and simultaneously by two firms, and it has been a dramatic producer of profits for neither.

Rarely is a new drug able to command a high price for any length of time because of scarcity, for researchers quickly find new ways of producing the drug at lower cost. However, it is the brief period of scarcity that makes the headlines. The first precious ampules of polio vaccine called forth angry charges of black market skulduggery and unfair distribution. But not many months later, thousands of dollars worth of vaccine was destroyed by its makers because it had become old and outdated waiting for customers.

Danger of Obsolescence

The pace of obsolescence has left the drug companies holding some monumental bags—the classic case, of course, being that of the Lederle pneumonia serum rabbits, whose whole reason for existence was undermined by the sulfas and the antibiotics.

As for their actual sources, new drugs, like gold, are where you find them. Often the clue pops up in the course of a search for something quite different.

Side Effect Studies Pay Off

For example, one major task of research is to study side effects, which are merely actions of a drug that are unwanted for a given purpose. Yet these side effects can become the drug's primary use. Years ago it was noted that the amphetamines, then used to shrink nasal membranes, stimulated the central nervous system and also caused patients to lose interest in eating. Now amphetamine compounds are widely prescribed as anti-depressants and to help reducers stay on their diets. The various tranquilizers were originally thought of as drugs to combat hypertension or inhibit nausea or decrease muscular tension; then researchers both inside and outside of the pharmaceutical companies became increasingly impressed by the drugs' mental actions.

Pursuit of "Failures"

The relentless pursuit of "failures" is another major avenue in pharmaceutical research. Over 5000 sulfa drugs have been formulated and tested, only to be discarded as not completely satisfactory. However, this ostensibly wasted effort (wasted, that is, in terms of its initial goal) has already produced tolbutamide, an interesting oral anti-

diabetic, and chlorothiazide, a potent oral diuretic which shows promise in controlling hypertension. And the study of the sulfonamides is still going on.

It Must Be Safe

However difficult the discovery, isolation, or synthesis of a new drug, determining its safety and usefulness is considerably more tedious and costly. The average new drug is from two to ten years old before it reaches drugstore shelves, and during this lengthy gestation period it has been ministered to by chemists, biochemists, physiologists, pharmacologists, statisticians, physicians, and other specialists. What is its chemical structure? How does it affect laboratory animals? What are its effects on the human body, desirable and undesirable? Is it safe? In doses of what size? How administered?

Such testing is obviously meticulous and time-consuming. It is also exceedingly expensive, as demonstrated by the history of cortisone, the first of the so-called "wonder hormones." The public first heard about it in 1949 through sensational stories of rheumatoid arthritis patients who almost literally picked up their beds and walked. During the five years between 1946 and 1951 the pharmaceutical companies gambled \$25 million on research into cortisone, ACTH, and similar hormones. The research sparked by the discovery of cortisone provided important new insights into body chemistry, and has led to the creation of uncounted additional steroid compounds.

The Cortisone Gamble

The original gamble on cortisone was taken one morning shortly after the end of World War II when a group of Merck & Co. researchers was gathered to hold obsequies over a drug known as Kendall's Compound A, so called because it had been the first compound isolated from the adrenal cortex by Dr. E. C. Kendall.

Merck found itself in this particular back-alley because of an intelligence report received by the government that Nazi aviators, allegedly given such a compound, were able to function at altitudes and under physical strains that were normally unbearable.

The report proved to be totally false, but that was not the question. Rather, the question was whether Merck & Co. should risk some additional millions of dollars in producing, by a tedious, many-staged, expensive method starting with oxbile, a mere five grams of Kendall's Compound E—since named cortisone. To Merck's eternal credit, it took the gamble. By improving their techniques as they worked, Merck chemists were

able to produce nearly four ounces of cortisone. They were four of the weightiest ounces in medical history.

No Golden Harvest

It so happened that Merck reaped no golden harvest for its gamble. Within a few months after the first announcement, researchers in another laboratory found a way to make cortisone that skipped the costly ox-bile method in favor of a technique that used a Mexican yam root as the starting point. Five drugs introduced later—hydrocortisone in 1952, prednisone and prednisolone in 1955, and methylprednisolone and triamcinolone in 1957—have taken over the most of the market, and Merck is but one of the principal suppliers.

Two Tough Hurdles

Before cortisone or any other new drug reaches the public, however, it must clear two crucial hurdles. Assuming that a prospective product comes through all the laboratory tests (and the testing arena is littered with the bones of promising failures), the drug must still be evaluated by a group of skeptical outsiders—physicians who will put it through clinical trials on actual patients. The results of their tests are in turn incorporated in an "NDA"—New Drug Application—presented to the U. S. Food and Drug Administration. Until the NDA is approved, usually a matter of months, all use of a new drug is strictly investigative and experimental, and the manufacturer foots the bill.

Just how complicated the Food and Drug Administration procedure is may be judged from the kinds of information the U. S. demands in an NDA: Give full reports of *all* investigations of the drug's safety . . . report *all* clinical tests by experts . . . give *complete* composition and method of manufacture . . . list *all* components . . . *full* description of processing and packaging . . . analytical controls . . . data on stability. Indeed, the mere list of questions fills two closely printed pages.

After an NDA has been subjected to months of scrutiny, the manufacturer gets a firm answer on whether he may or may not offer the drug for sale, and under what conditions. But the jury of clinicians may be said to sit forever, since clinical studies continue long after the drug is marketed. In 1951, the first full year after cortisone came on the market, it was the subject of 767 clinical studies in the U. S.

Continuing Clinical Studies

These continuing clinical studies were made partly to fix more precisely the known action of the drug, but still more to investigate its pos-

sible usefulness in such varied conditions as jaundice, premature childbirth, skin disease, burns, eye disorders, nutrition, etc. To date, some 20,000 different steroids have been developed, less than two score of which have any apparent medical use; and a nonchemist could well regard all but those few as expensive failures.

But are they? Many of these compounds serve to mark off blind alleys down which other researchers will not need to travel. Others yield valuable bits of knowledge about bodily processes. Still others show interesting special properties worth investigating further for their own sake. For example, some steroids apparently are associated with certain types of cancer—about 30 steroids a year are being tested against breast cancer. All this seems a long way from rheumatoid arthritis, but the pharmaceutical researcher is seldom surprised by the unexpected crossings of biological trails.

Informing the Physician

Today's swift pace of medical advance creates a formidable problem in keeping up with current knowledge. It is not the drug manufacturer's business to train the physician, but the drug maker *is* responsible for informing physicians about new products. This job falls largely to the "detailman," who is an employee of the pharmaceutical company. But his "customer" is wise, experienced, given to pointed questions. A detailman not thoroughly informed about all the work proceeding elsewhere on the type of drug he discusses has little hope of gaining the doctor's respect. Since a detailman can make but six to eight calls a day, his employer's investment in current medical education is substantial.

The other major channels from pharmaceutical maker to physician are direct mail and ads in medical journals, both usually containing references to scientific articles in which the physician can read reports of drug uses and actions. Such advertising, of course, costs money. Yet according to *The Journal of the American Medical Association*, the elimination of journal advertising would permit the cost of a 50-cent capsule to be reduced only to 48 cents. But elimination of such advertising would preclude the mass market necessary to bring the price of the drug down to 50 cents in the first place.

Objective of the Industry

The physician has been with us since before the dawn of recorded history, and the purveyor of drugs has been with us almost as long. The new thing under the sun is the pharmaceutical industry researcher, skilled in the creation of poten-

tial new drugs by the tens of thousands. Only a handful of these drugs ever prove useful. However, the pharmaceutical industry does not regard the effort as wasted; otherwise the \$125 million ploughed back into research last year could have been distributed as profits. The industry's very nature is such that it prospers to the extent that it can help sick people get well, and well people stay well. For the pharmaceutical industry, good medicine is good business.

Ready To Take the Risks

In the most direct sense, the pharmaceutical industry is a defense industry. No government appropriations guarantee the industry a profit or even the recovery of its investment when it forges new weapon. Yet the pharmaceutical industry is always ready on short notice to mobilize its highly specialized skills and plants at punishing cost to meet some national emergency. One such case was the screening of some 5000 chemicals in search of a potent anti-malarial drug. Another was the recent crash research and production program to provide a vaccine against Asian influenza—a program undertaken with no certainty that the epidemic would actually develop or that the vaccine would be purchased.

This impressive pool of knowledge and equipment exists nowhere outside the pharmaceutical industry. It would take years—even decades—to re-create it by seeking out thousands of specialists and teaching them to operate it smoothly in intricate teamwork. This standby readiness is a priceless national asset. And it also has one further advantage: It is financed wholly by the industry itself.

Federal Money Appropriated For Civil Defense

Before adjournment the 85th Congress appropriated \$45,285,000 to OCDM for fiscal 1959 operations. \$18.5 million was authorized for operations; \$18 million for emergency supplies and stockpiling; \$2 million for research and development; \$2.5 million for educational activities; and \$2 million for radiological instruments. An additional appropriation of nearly \$2.3 million was made to the Office of Defense Mobilization before the merger with FCDA.

The total amount requested was \$76,473,000. The Congress failed to appropriate funds for the announced federal shelter program. In addition, no new money was authorized for federal contributions to the states or for the requested fifty-fifty sharing of salaries of state and local officials.

New Members of OSMA

The following are the names of the new members of the Ohio State Medical Association since November 1, 1958. The list shows the county in which they are affiliated, city in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

Cuyahoga County (all Cleveland)

William G. Ansley
Jerrel W. Benson
John I. Biskind
Bernard L. Charms
Harry R. Claypool
Donald F. Dohn
Sheldon Loeb
John J. Poland
David Rubin
Imre Schmidt
Frederick T. Suppes
James R. Lasch, Solon

Darke County

Lowell D. Mann,
New Madison

Harrison County

William Allen, Cadiz

Jackson County

Gordon S. Leonard, Jackson

Lucas County (all Toledo)

John F. Brunner
Burril B. Fine
Charles H. Frie
John G. Kramer

Scioto County

Harlan Williams, Minford

Summit County

Leon D. Carson,
Cuyahoga Falls
Buel S. Smith, Akron

Wood County

Robert E. Johnson,
Perrysburg

COMING MEETINGS

Ohio State Medical Association, 1959 Annual Meeting, April 21-24, Columbus.

American College of Physicians, Ohio Regional Meeting, Veterans Administration Hospital, Cincinnati, January 22.

AMA Law Department, Regional Medicolegal Conference, Hotel Cleveland, Cleveland, April 4-5.

Chicago Medical Society, Annual Clinical Conference, Palmer House, Chicago, March 2-5.

Congress on Industrial Health of the AMA, Netherland Hilton Hotel, Cincinnati, February 16 and 17.

Congress on Medical Education and Licensure, Chicago, February 7-10.

Institute on Industrial Health, and Department of Ophthalmology, University of Cincinnati, Industrial Eye Problems, March 9-12.

Institute on Steroid Therapy, Ohio State University, January 8.

Northwestern Ohio Medical Association, Findlay Country Club, October 7, all-day session; registration 9:00 a.m.; first speaker, 9:45 a.m.

Ohio Orthopaedic Society, Meeting, Akron, April 10, 11.

Ohio Society of Internal Medicine, Netherland Hilton Hotel, Cincinnati, January 21.

Veterans Administration, Series of Clinical Courses, Wednesday Evenings, Cleveland.

In Memoriam . . .

Roy S. Binkley, M. D., Dayton; Ohio State University College of Medicine, 1911; aged 75; died November 26; member of the Ohio State Medical Association and the American Medical Association; former delegate to the OSMA and alternate delegate to the AMA; member of the American Academy of Ophthalmology and Otolaryngology. A native of Dayton, Dr. Binkley served all of his professional career there. An active worker in medical organization affairs, he was a past-president of the Montgomery County Medical Society and served on a number of local committees. He is survived by his widow.

Porter Bruce Brockway, M. D., Toledo; Rush Medical College, 1900; aged 83; died October 28; member of the Ohio State Medical Association and recipient of the OSMA 50-Year Award; member of the American Medical Association and the American Public Health Association. A physician in Toledo since 1900, Dr. Brockway founded the health service in the Toledo public schools and was its director for 33 years. From 1945 to the time of his death, he was director of the Toledo Area Sanitary District. A veteran of the Navy medical service during World War I, he was active in a number of community programs; was a member of the Methodist Church and a 50-Year Mason. A charter member of the Toledo Chapter of Round Table International, he was a past international president of that organization. Surviving are his widow and two sons.

Eric Kent Clarke, M. D., Lynn Haven, Florida; University of Toronto Faculty of Medicine, 1916; aged 64; died November 19; member of the Ohio State Medical Association, the American Medical Association and the American Psychiatric Association; diplomate of the American Board of Psychiatry and Neurology. Dr. Clarke was medical director of the Erie County Guidance Center in Sandusky from 1954 to 1956. He was a former director of the Minneapolis Institute and held assignments at the Oak Ridge, Tenn., and Los Alamos, N. M. laboratories. Surviving are his widow and a son.

Thomas Kernan Golden, M. D., Youngstown; Georgetown University School of Medicine, 1928; aged 54; died November 19; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons; member of the Ohio State Orthopedic Society. A practicing physician in the Youngstown area for many years, Dr. Golden was active in many voluntary activities involving

crippled children. He was a member of the Chesterton Club, the Youngstown Country Club, the Catholic Church and the Knights of Columbus. Surviving are his widow, three sons, a daughter, two sisters and a brother.

Edward William Lakner, M. D., Cleveland; University of Michigan Medical School, 1930; aged 55; died November 18; recent member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons; member of the American Academy of Obstetrics and Gynecology. A native of Cleveland, Dr. Lakner served all of his professional career there, where he was active on a number of committees of the Academy of Medicine of Cleveland. Surviving are his widow, a son, a daughter and his mother.

Clifford J. Pollock, M. D., Holland, Lucas County; Toledo Medical College, 1912; aged 74; died November 30; member of the Ohio State Medical Association and the American Medical Association. Dr. Pollock served the greater part of his professional career in the Holland community where he was the only doctor for many years. In 1953 the community honored him by designating "Doc Pollock Day." He was active in many community affairs; was active on the local board of education, the Methodist Church and other local groups. Surviving are his widow, a daughter, two sons, a sister and three brothers.

William A. Quinn, M. D., Portsmouth; George Washington University School of Medicine, 1903; aged 85; died November 14; member of the Ohio State Medical Association and the American Medical Association; recipient of the OSMA 50-Year Award. A practicing physician in Portsmouth for many years, Dr. Quinn served more than four years as Scioto County coroner. A veteran of the Mexican Expedition and World War I, he was member of the Presbyterian Church and a 32nd Degree Mason. Survivors include three sons, a daughter and a brother.

John E. Roose, M. D., Tiffin; Western Reserve University School of Medicine, 1946; aged 36; died November 11; member of the Ohio State Medical Association and the American Medical Association. A veteran of World War II, during which he served in the Army Medical Corps, Dr. Roose began his practice in Tiffin following residency work at Western Reserve in pediatrics. He was a past-president of the Seneca County Medical Society and served on a number of the Society's committees; was on the professional

advisory council of the Betty Jane Memorial Rehabilitation Center and a trustee of the local and North Central Mental Health Associations. Other affiliations included memberships in the Methodist Church and the Elks Lodge. Surviving are his widow, five children, his parents, a brother and a sister.

C. Roy Steingrube, M. D., Cincinnati; University of Cincinnati College of Medicine, 1929; aged 55; died December 2; member of the Ohio State Medical Association. Dr. Steingrube was a practicing physician for many years in the eastern part of Greater Cincinnati and recently was Hamilton County health commissioner. He previously served on the County Board of Health. Affiliations included memberships in the International College of Surgeons, the Ohio Public Health Federation, Royal Society of Health, London, England. Surviving are his widow, a son and two daughters.

Harry M. Strachan, M. D., Cleveland; University of Louisville School of Medicine, 1911; aged 71; died November 18; member of the Ohio State Medical Association, the American Medical Association and the Aero Medical Association; diplomate of the American Board of Preventive Medicine. Dr. Strachan moved his practice to Cleveland in 1923 after service in the Medical Corps during World War I. Before the war he did research work for the Parke, Davis & Company in Detroit. He was examiner for several insurance companies and former examiner for the Civil Aeronautics Administration. Surviving are his widow and two sons.

George Y. Swickard, M. D., Orange, Texas; Ohio State University College of Medicine, 1931; aged 52; died on or about November 22. Dr. Swickard practiced for about 10 years in Sunbury, Delaware County, leaving there in 1943. He had been practicing in Texas for 13 years. Survivors include his widow, a son and a daughter.

Arthur W. Thomas, M. D., Ashtabula; Ohio State University College of Medicine, 1914; aged 69; died November 26; former member of the Ohio State Medical Association. A past-president of the Mahoning County Medical Society, Dr. Thomas practiced pediatrics in Youngstown from 1920 to 1934. He was for several years chief of the state Child Health Division in Columbus. In 1947 he went to Cleveland where he was head of the city child hygiene and maternal welfare division. A daughter and three sisters survive.

McLeod M. Watkins, M. D., Cincinnati; Vanderbilt University College of Medicine, 1957; aged 24; died November 4 in a traffic accident.

Dr. Watkins was taking intern training at General Hospital. His mother, of Ocean Springs, Miss., survives.

Jerome Zeigler, M. D., Cincinnati; Ohio State University College of Medicine, 1920; aged 64; died December 6; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. A practicing physician in Cincinnati for many years, Dr. Zeigler was medical director for the City's Shoemaker Health Center since its founding in 1926. He also was medical advisor to Hospital Care Corporation, the Cincinnati area Blue Cross plan, and was instructor in clinical medicine at the University of Cincinnati College of Medicine. Affiliations included memberships in a number of community and fraternal organizations. Survivors include his widow, a daughter, a son and a brother.

Federal Grants for Limited Studies In Psychiatric Work Available

The National Institute of Mental Health is offering grant support for a training program for general practitioners and other physicians engaged in the practice of medicine other than psychiatry. Funds are available during the current year (Fiscal year 1959) for these grants and training institutions may submit applications at any time.

The program has two purposes:

I. To foster the development of postgraduate training in psychiatry for the practitioners who wish to increase their psychiatric knowledge and skills.

Grant support is being offered to medical schools, hospitals, clinics, and medical and psychiatric societies for the development and expansion of such postgraduate training.

Physicians interested in obtaining this type of training should apply to medical schools, hospitals, clinics, and medical or psychiatric societies which have, or are developing, such training opportunities.

II. To provide support at an adequate level for psychiatric residency training for physicians in practice who wish to become psychiatrists. Training stipends up to a maximum of \$12,000 a year are available.

Physicians interested in support for this type of training should apply to training institutions which are approved for psychiatric residency training.

Inquiries about the program should be sent to Dr. Seymour D. Vestermark, Chief, Training Branch, National Institute of Mental Health, National Institutes of Health, Bethesda 14, Md.

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SEARLE

Survey Shows People Want To Choose Own Doctor

More than three-fourths of the population of the United States want to choose their own doctor. In addition, they want to assume all or part of the responsibility for paying their doctor bills.

These were among the findings in a survey conducted among a sampling of the adult general population by Opinion Research Corporation, Princeton, N. J., for the American Medical Association. The purpose of the study was to explore attitudes about the choice of physicians.

The study also showed that:

Eighty-eight per cent of the population believe the right to see the same doctor regularly is of vital importance.

Eighty-nine per cent believe that medical care in this country has improved over the past 20 years. Half of these persons ascribe the improvement to more and better research and advances in medical science.

Seventy-six per cent of the people said they wanted to choose their own physicians; 13 per cent saw no difference in whether they or someone else chooses their physician; 8 per cent preferred to have someone else choose, and 3 per cent had no opinion.

In answer to further questioning, 93 per cent of those surveyed felt that free choice would give them more confidence in the doctor; 84 per cent thought doctors would take a more personal interest in them, and 79 per cent believed they would have less trouble getting the doctor to make a home call.

Concerning the right to see the same physician all the time, 88 per cent felt this right to be very important. Of the 12 per cent who did not feel such continuity to be of vital importance, 8 per cent saw no difference in whether or not they saw the same doctor every time, and 4 per cent gave other comments.

In answering still another set of questions, 93 per cent felt such continuity would give them more confidence in the doctor; 92 per cent thought doctors would take a more personal interest in them, and 84 per cent believed they would have less trouble getting a doctor to make a house call.

When queried about the main advantages of a regular doctor, those interviewed gave a variety of reasons. Sixty-two per cent cited the physician's knowledge of their medical history. They said, "He knows your system inside and out from dealing with you regularly, he knows what you've had."

Also mentioned by 30 per cent was reliability on

Group Life Insurance Plan Extension Granted

An extension of time has been granted by The Union Central Life Insurance Company for Ohio State Medical Association members and their interested employees to enroll in the OSMA Group Life Insurance plan. They now have until January 31 to send in their applications to Turner & Shepard, Inc., 20 S. Third St., Columbus 15.

The same rules still apply . . . if 1,000 new applications are received by January 31, all applications for the basic amount will be approved and certificates issued without evidence of insurability. If less than 1,000 enroll, only those who are insurable will be issued certificates, effective January 1.

emergency calls; confidence in the physician by 21 per cent, and a closer relationship between doctor and patient by 18 per cent.

Concerning the payment of medical bills, a total of 79 per cent wanted to assume all or part of the responsibility for paying their doctor bills either by direct payment or by paying part of insurance premiums.

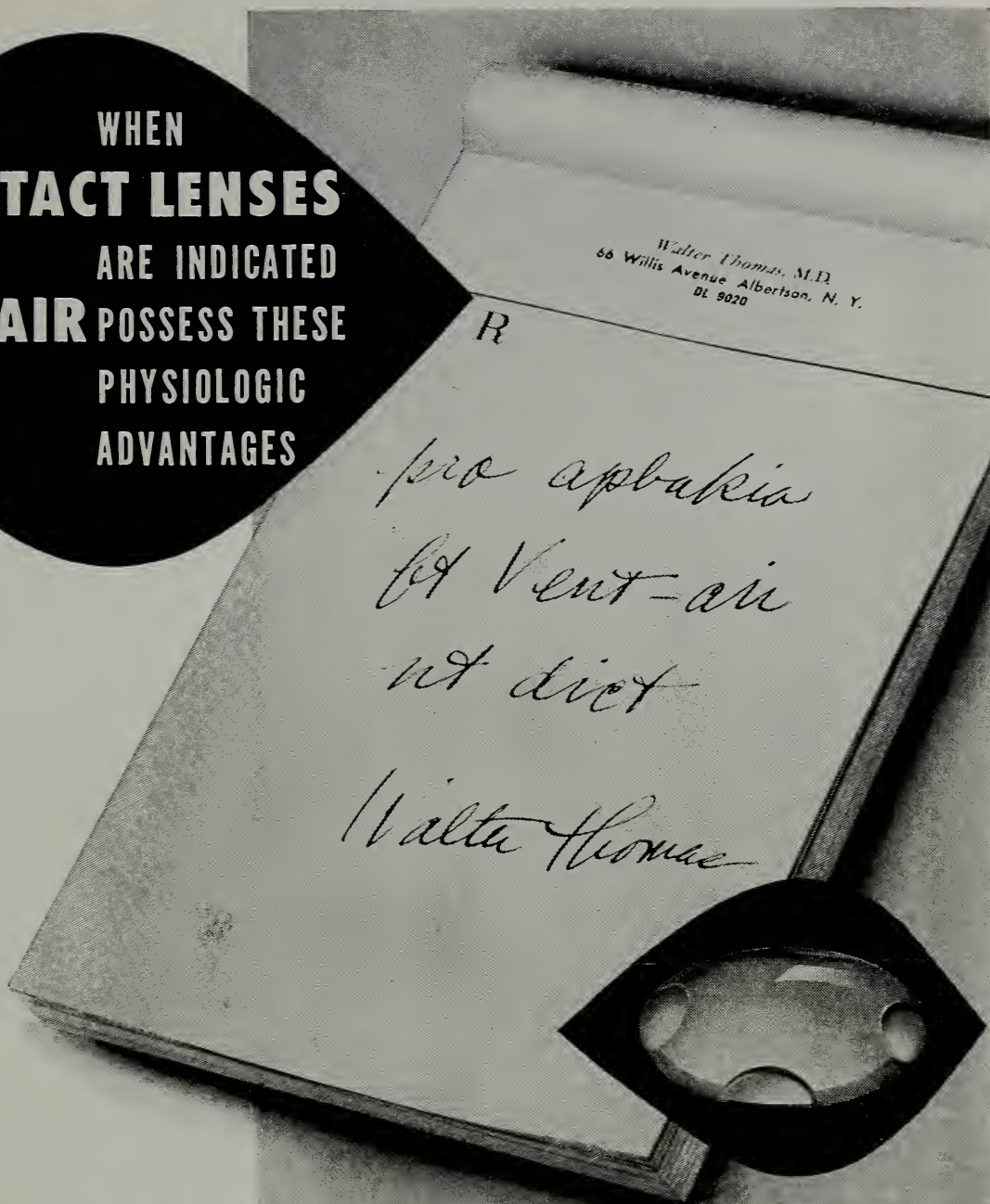
The 79 per cent breaks down into the following: 16 per cent for paying all doctor bills directly; 16 per cent for paying all costs of insurance plans, and 47 per cent for paying part of the cost of an insurance plan. The remaining 21 per cent favored someone else's paying the bills.

Fort Steuben Academy Holds Meetings

"What To Do When in Children's Surgery," was the topic of discussion for the November 11 dinner meeting of the Fort Steuben Academy of Medicine in Steubenville. Speakers were Dr. H. William Clatworthy, chief of surgical service, The Children's Hospital, Columbus, and Dr. Warren D. Leslie, medical staff, Ohio Valley General Hospital and North Wheeling Hospital, Wheeling, W. Va.

"Surgical Problems in the Treatment of Biliary Tract Disease," was the theme of the December 9 program for the Fort Steuben Academy of Medicine. Speakers were Dr. John T. Reynolds, associate professor of surgery, University of Illinois College of Medicine; and Dr. Albert Winston, surgical staff, Ohio Valley Hospital, Steubenville. The group met for dinner and the program at the Ft. Steuben Hotel in Steubenville.

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Health Services School-Age Children Need. Focuses attention on all health needs of school children, essential health services and the role of the physician. Write OSMA, 79 E. State Street, Columbus 15, Ohio.

Cardiovascular Diseases in the U. S. — Facts and Figures. Statistical handbook deals with number, leading causes and ages of cardiovascular deaths, along with death rates by race and sex. Write American Heart Association, 44 East 23rd Street, New York 10, N. Y.

The Doctor and The Law, monthly medico-legal newsletter written by George E. Hall, J. D., AMA Legal Department staff associate. Periodically reminds doctors of medico-legal matters and puts them on guard against potentially dangerous legal situations. (\$10 per year.) Write Callaghan and Company, 6141 N. Cicero Avenue, Chicago 46, Illinois.

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Activities of County Societies . . .

First District

(COUNCILOR: CHARLES W. HOYT, M. D.,
CINCINNATI)

CLINTON

Dr. Kelley Hale, practicing physician for a half century in the Wilmington area, was honored at the October 22 meeting of the Clinton County Medical Society, with the 50-Year Award of the Ohio State Medical Association.

Dr. Charles W. Hoyt, Cincinnati, Councilor of the First District, presented the 50-Year Award. Dr. Foster J. Boyd spoke on the topic, "Reflections of a younger surgeon on Dr. Kelley Hale." Several others also spoke in behalf of Dr. Hale.

HAMILTON

At the November 11 meeting of the Academy of Medicine of Cincinnati, Fifty-Year Awards were presented to seven physicians in the name of the Ohio State Medical Association by Dr. Charles W. Hoyt, First District Councilor. Those who received the awards were: Drs. S. Bertha Dauch, Fred H. Finlaw, Charles E. Howard, E. M. Strasser, Kurt Tschiasny, Adam P. Basinger and Edgar B. Snyder.

Second District

(COUNCILOR: R. DEAN DOOLEY, M. D., DAYTON)

CLARK

Dr. William P. Montanus of 301 W. Home Rd., November 17 became the 77th president of the Clark County Medical Society as the 108-year-old organization held its annual meeting in Hotel Shawnee, Springfield.

Dr. Montanus, a member of the society since 1946, was 1958 president-elect.

He succeeds Dr. E. W. Schilke.

Members elected Dr. John A. Davidson of 650 S. Tanglewood Dr. as 1959 president-elect.

Other officers, all beginning the second year of two year terms, are Dr. Martin J. Cook, of 110 E. First St., secretary; Dr. Naoma D. Green, treasurer; Dr. Ray M. Turner and Dr. John M. Summers, delegates, and Dr. J. Harold Shanklin and Dr. Schilke, alternates.

Society President Montanus completed his undergraduate work at Georgetown University, Washington, D. C., in 1931.

He was graduated from the University of Cincinnati Medical School in 1935. From that time until 1942 Dr. Montanus was assistant resident

and resident surgeon, spending all but one year, part of 1939 and 1940, at Cincinnati General Hospital. The other year was spent in that capacity at the University of California Hospital, Los Angeles.

In 1942 Dr. Montanus entered the Army, serving 20 months in the European Theater. He served as a major. He began his practice in Springfield in 1946.

Dr. Davidson was treasurer of the society in 1954.

Guest speaker at the meeting was Dr. Max M. Zininger, professor of surgery at the University of Cincinnati. His topic was "Diverticulitis."

Ferd H. Krueckeberg, executive vice-president of the Springfield Development Council, spoke briefly at the session. He told the doctors of the work of the council in the 10 months since he has been here and urged the organization's support for the council's program.—Tom Duross, Ex. Secretary.

DARKE

Dr. W. Dudley Johnson, Division of Chronic Diseases of the Ohio Department of Health, was principal speaker at the November 21 dinner meeting of the Darke County Medical Society. He discussed chronic diseases as they relate to public health and to physicians in practice.

MONTGOMERY

Dr. Robert P. Glover, director of thoracic and cardiovascular research and surgery, Presbyterian Hospital, was guest speaker at the November 7 meeting of the Montgomery County Medical Society in Dayton. His subject was "The Place of Bilateral Internal Mammary Artery Ligation in the Treatment of Coronary Insufficiency."

The social hour and dinner meeting was held at the Van Cleve Hotel.

Third District

(COUNCILOR: FLOYD M. ELLIOTT, M. D., ADA)

ALLEN

The Lima and Allen County Academy of Medicine held a dinner meeting at the Shawnee Country Club, Lima, on November 18. Guest speaker was Dr. John L. Bell, Cook County Hospital, Chicago, who spoke on the care of burns.

Dr. J. Dudfield Rose, appearing under auspices of the St. Rita's Hospital, spoke to members of the local Medical Society on the subject of "New-

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Ascorbic acid50.0 mg.

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est Developments in Diagnosis and Treatment of Billiary Tract Dyskinesia."

Dr. Rose, well known British physician, is from London, England.

SENECA

Dr. Thomas W. Watkins, Tiffin, was elected president of the Seneca County Medical Society when the doctors held their annual reorganization meeting and dinner Tuesday evening, November 18 in the Black Cat restaurant in Fostoria.

Dr. Emmett Sheeran, Fostoria, was elected vice-president and Dr. Robert R. Schwalenberg, Tiffin, was named secretary.—Tiffin Advertiser-Tribune.

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

PUTNAM

October meeting of Putnam Society was held at Oak Restaurant, Ottawa, October 7.

Guest speaker was Bernard Glass, M. D., Lima neurosurgeon, whose subject was "The Differential Diagnosis of Arm Pain." Dr. Glass presented his subject in great detail. Origin and location of nerves and relation to bony structures was shown by colored slides. Appropriate clinical cases were discussed.—H. N. Trumbull, M. D., Correspondent.

WILLIAMS

The Williams County Medical Society held its annual combined dinner meeting with the Williams County General Hospital Medical Staff on December 9, at the Elder Hotel in Bryan, Ohio. The guest speaker was councilor Paul Orr, M. D. of Perrysburg, Ohio. In his enlightening speech among other things he talked on "The Trend of Medicine in the United States."

Fifth District

(COUNCILOR: GEORGE W. PETZNICK, M. D., CLEVELAND)

CUYAHOGA

"The Doctor Speaks" is the theme of a series of weekly radio programs being presented by the Cleveland Academy of Medicine. Topics of the early programs included the following:

"How to Select a Family Doctor," "What Kind of Health Insurance Should I Have?" "Is Alcoholism a Disease?" "When Should I Call a Doctor For My Child?" and "How Serious is Nuclear Fall-Out?"

Robert A. Lang, executive secretary of the Academy of Medicine, is moderator of the program.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

STARK

The Stark County Medical Society met at the Belden Hotel, Canton, on November 13, where Dr. Arthur Weatherhead, Cleveland Clinic, spoke on the subject, "The Early Recognition and Treatment of Depression."

SUMMIT

Dr. Geo. J. Hamwi, professor of medicine, Ohio State University College of Medicine, was speaker for the December 2 program of the Summit County Medical Society. His topic was, "Recent Advances in Endocrinology." Dinner was held in the Akron City Club after which the program was conducted in the City Hospital Auditorium.

TRUMBULL

Fall meetings of the Trumbull County Medical Society included the following program features:

At the October meeting Dr. Cyrus Maxwell, of the AMA Washington Office, was guest speaker. He discussed the theme of how doctors can keep free medical enterprise in this country and informed the group of what is in store from the legislative standpoint on health and medical matters.

At the November 19 meeting Dr. Michael Brennan, Henry Ford Hospital, Detroit, addressed the dinner meeting at the Trumbull County Club on the subject of tumors. A concise business meeting also was held during which committee reports were heard.

The final 1958 meeting of the Society was a Christmas dinner and dance at the Squaw Creek Country Club, where doctors and their wives enjoyed a social evening, after the brief business session.

The Society's council is in process of studying the revised constitution as proposed by the constitution committee and will submit its report to a coming meeting.

With the auxiliary working on the essay contest to be conducted in high schools, the Society decided to vote prizes for the best essays on a local level. The prizes are \$25, \$15 and \$10.

Seventh District

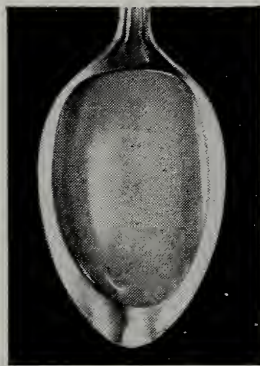
(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

BELMONT

Dr. Jonathan Forman, Columbus, was speaker for the November 20 meeting of the Belmont County Medical Society and Auxiliary. His subject

(Continued on Page 118)

in a form



to fit

every



antibiotic



need



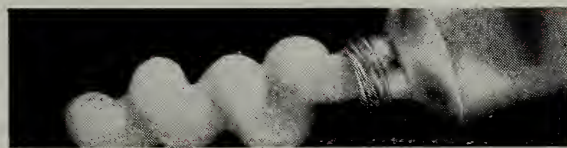
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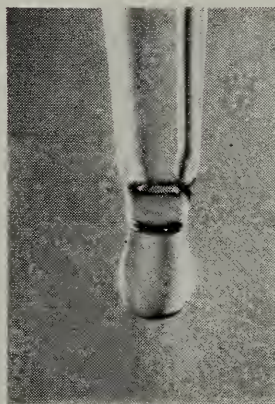
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OSMA Exhibits Before Parent-Teacher Congress



Pictured is the exhibit sponsored by the Committee on School Health of the Ohio State Medical Association at the Annual Ohio Congress of Parents and Teachers, Cincinnati, October 6, 7 and 8. Visiting the exhibit are Mrs. John Cox, Seville, pre-school health chairman of the Ohio Congress of Parents and Teachers, left, and Mrs. Carl L. Petersilge, Newark.

The exhibit was staffed by Mr. Hart F. Page, secretary to the OSMA Committee on School Health. Several thousand copies of various reprints and booklets on school health were distributed. Guest speakers at conferences devoted to pre-school health and school health during the meeting were Dr. Carl Wilzbach, Cincinnati, a member of the OSMA Committee on School Health, and Mr. Page.

Story Was Misleading

In the November, 1958, issue of *The Ohio State Medical Journal*, page 1476, material from a bulletin of the Ohio Hospital Association was quoted. It referred to a number of periodicals on disaster planning, indicating that they could be obtained from the Library of the American Hospital Association, Chicago.

The AHA Library has informed *The Journal* that it does not lend periodicals. It states it does lend clippings from periodicals but that this service is limited by the number of periodicals available for clipping and, further, that the Library's services are limited almost exclusively to member hospitals.

Therefore, physicians who may desire any of the periodicals referred to in the article should not count on securing the material from the AHA Library on a loan basis. Some of the booklets are AHA publications and are sold by the association.

AMA Medicolegal Conference Scheduled in Cleveland

Cleveland will be host to one of three regional medicolegal conferences sponsored by the AMA Law Department in the near future. The program will be held in the Hotel Cleveland, April 4-5. The conference which will draw physicians and attorneys from surrounding states as well as from Ohio is planned as part of a continuing effort to create a better working relationship between lawyers and doctors.

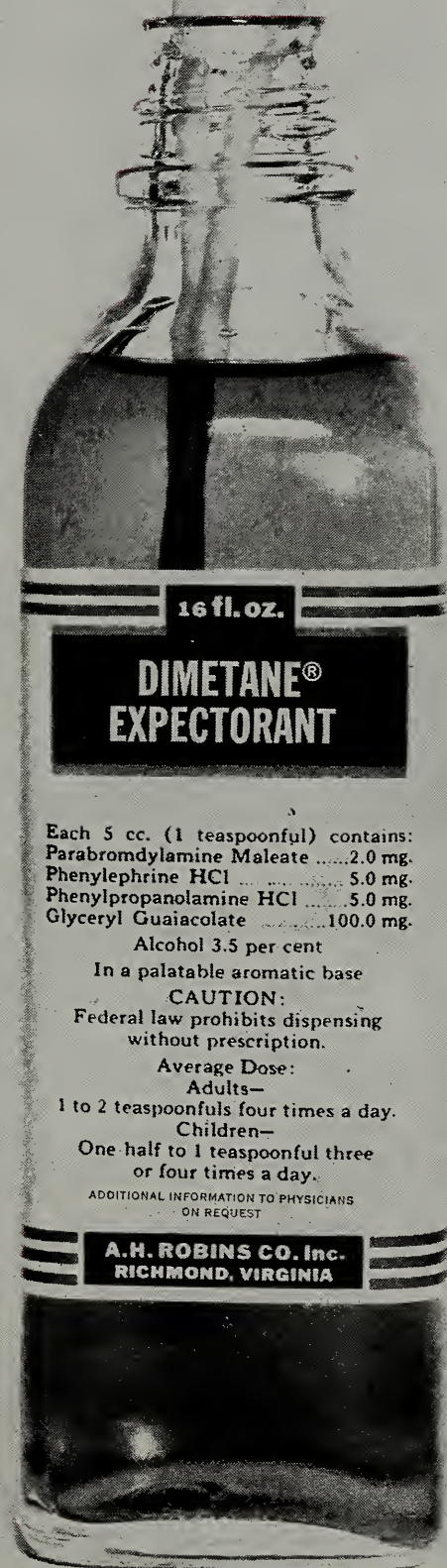
Postgraduate Courses

The Frank E. Bunts Educational Institute, affiliated with the Cleveland Clinic, 2020 East 93rd Street, Cleveland, is offering two postgraduate courses in January. Themes are as follows: January 7-8, "Recent Advances in Surgery"; January 14-15, "Neurology and Psychiatry."

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was, "Some Old and New Concepts in Disease." The dinner meeting was held at the Belmont Hills Country Club.

COLUMBIANA

A symposium on interprofessional relationships was held when the Columbiana County Bar Association entertained members of the Columbiana County Medical and Dental Society on November 17 at the Country Club, East Liverpool. Dr. Samuel R. Gerber, Cleveland, Cuyahoga County coroner, and Dr. Lewis K. Reed, Youngstown, were principal speakers.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

SCIOTO

"Modern Treatment of Lymphomas and Leukemia," was the topic discussed by Dr. Robert Wall, Ohio State University, Columbus, at the October 13 meeting of the Scioto County Medical Society in Portsmouth.

Dr. Richard T. F. Schmidt, Department of Obstetrics and Gynecology, University of Cincinnati, was guest speaker at the November 17 meeting of the Society in Portsmouth. His subject was "The Use and Abuse of Hormone Therapy in Gynecology." Another feature of the program was the showing of a film on hypothyroidism.

Eleventh District

COUNCILOR: H. T. PEASE, M. D., WADSWORTH

LORAIN

The regular meeting of the Lorain County Medical Society was held November 11 at the Oberlin Inn, with 68 members present.

Dr. Arnold Windt was elected to active membership.

Dr. Paul J. Kopsch was congratulated upon having been elected county coroner.

The County Society heard a fine report from its Liaison Committee with County Welfare. Progress can be made by personal contact, exchange of ideas, elimination of misconception and misunderstanding.

To further this concept the guest speaker, Mr. Wilson Posey of the Ohio Citizens Council for Health and Welfare, presented a program entitled "People, Dollars and Sense."—L. C. Meredith, M. D., Secretary-Treasurer.

Seventy members of Lorain County Medical Society attended the Annual Meeting held at Oberlin Inn on December 9. The main order of business was the election of officers, and the slate prepared by the Nominating Committee received unanimous support. Dr. Denis A. Radefeld of Lorain will serve as president for the coming

year, with Harold E. McDonald, (Elyria), president-elect for 1960, John Halley (Vermilion), vice-president, L. C. Meredith (Elyria), re-elected secretary-treasurer, O. H. Schettler (Oberlin), Board of Censors, and G. R. Wiseman (Amherst), delegate.

Reports were given by Dr. James T. Stephens, chairman of Education Committee; Dr. John J. Wherry, chairman of Insurance Committee; and Dr. O. H. Schettler, chairman of Committee for Liaison with County Welfare.

Dr. Ben V. Myers, 1958 president, thanked committees and all members for their cooperation and support during the year. Following their reports, both Dr. Myers, president, and Dr. L. C. Meredith, secretary-treasurer, were accorded a standing ovation for the outstanding accomplishments of the year.

In taking over from Dr. Myers, Dr. Radefeld pledged his best efforts that the progress of the Society should be maintained and furthered. He then called upon Dr. Lester H. Trufant, chairman of the Historical Committee, to give a report of their findings as the program of the evening. Dr. Trufant presented a scholarly and most interesting report of the beginnings of medical education and organized medicine in this country, as well as the state of Ohio and the local Society. His findings over the past months had filled in many blanks before 1920, since which time records of Lorain County Medical Society have been adequate. Still more information of the early days will be sought.

Great interest was evidenced in a doctor's saddlebags and contents, used in Carlisle township in 1835. Notebooks with remedies used at that time served to point up the sharp contrast between medical practice at that time and in the present day. Serving with Dr. Trufant on the Historical Committee were Drs. Valloyd Adair, Birt E. Garver and George D. Nicholas—men whose knowledge of the Society's activity reaches back to the early years of the century.

Dr. Harry E. Hartmann of Wellington, transferring from Medina County, was unanimously approved for associate membership in Lorain County Medical Society. Dr. B. V. Myers announced Dr. Howard P. Taylor of Cleveland Clinic as the program speaker for the January meeting, when he will discuss "Hypnosis."

MEDINA

The Medina County Medical Society held its annual meeting for the election of officers, November 20, with the following officers elected for 1959: President, Robert E. Smith, M. D., Medina; Vice-President, E. A. Ernst, Lodi; Secre-

(Continued on Page 120)

Allergy-free...all day... with this much medication



Typically, the allergic patient can enjoy a whole day's freedom from symptoms with just one Pyribenzamine Lontab in the morning—a whole night of restful sleep with just one Lontab in the evening.

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For patients who need only periodic medication, regular Pyribenzamine tablets provide fast, dependable action, with a minimum of undesirable side effects.

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tary-Treasurer, W. G. Halley, M. D., Lodi; Delegate to the Ohio State Medical Association, J. N. M. Klotz, M. D., Wadsworth; Alternate Delegate to the OSMA, Richard Avery, Seville; Legislative Committeemen, R. L. Mansell, M. D., Medina.—W. G. Halley, M. D., President, 1958.

RICHLAND

At the meeting held on November 20 at the Westbrook Country Club in Mansfield, several items of business were discussed. The Society voted to cooperate with the Health Department's mass chest x-ray program by having an accompanying diabetic detection program.

The Society also voted to cooperate in erecting and maintaining a dispensary for the children at the new Friendly House Camp.

A vote of appreciation and encouragement to the Red Cross Volunteer Aides who work with the Bloodmobile was expressed.

At the conclusion of the Business Meeting Dr. Harry Wain, local City-County health commissioner, introduced Dr. F. H. Wentworth of the State Health Department, who spoke on "Resistant Staphylococcal Infections."

At the conclusion of the meeting, Dr. H. T. Pease, District Councilor, was introduced and mentioned the importance of good public relations between the Society and the general public. He also emphasized the importance of the attendance of newly elected County Society officers at the meeting of officers to be held in Columbus on February 22.—John J. Clark, M. D., Secretary.

WAYNE

Dr. D. G. Gillespie, assistant professor of medicine at Western Reserve University, spoke before the Wayne County Medical Society on November 11 at the Wooster Community Hospital in Wooster. He spoke on the subject of evaluation of patients with dyspnea.

Bibliography of Aviation Medicine Available in Book Form

The Aero Medical Association, in cooperation with the Library of Congress, has completed arrangements to publish a comprehensive annotated bibliography of aviation medical literature for 1953, according to an announcement by Brigadier General M. S. White, USAF (MC), Washington, D. C., president of the society. The volume will be off the press early in January.

Entitled, *Aviation Medicine: An Annotated Bibliography, Vol. II (1953 Literature)*, the new bibliography will be available from the publication office of the Aero Medical Association, 2642 University Avenue, St. Paul 14, Minnesota. The price is \$5.00, sent postpaid in the United States and Canada.



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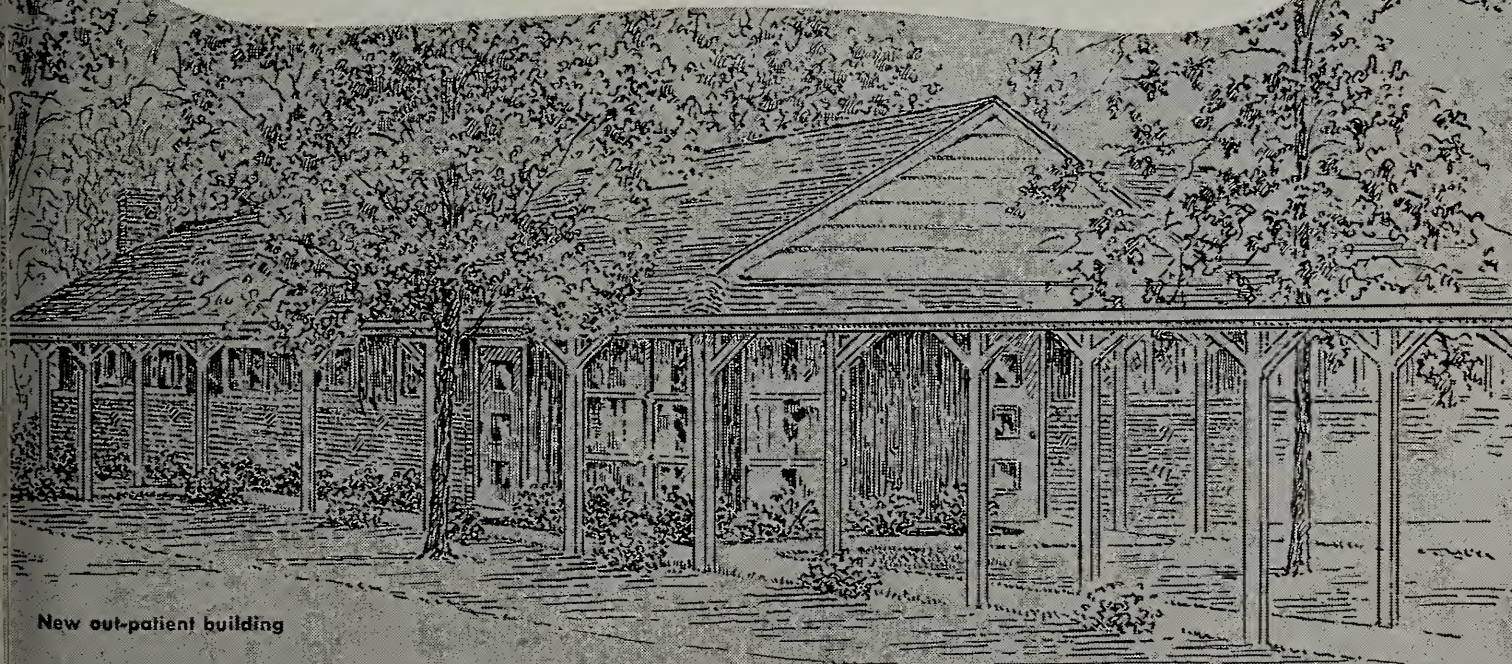
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Activities of Woman's Auxiliary . . .

CHAIRMAN PUBLICITY COMMITTEE—Mrs. W. J. Horger,
1100 Ohio Ave., East Liverpool, Ohio
(See Page 5 for roster of officers.)

COLUMBIANA

Mrs. Fred Banfield entertained the auxiliary at a Tea at her home in Highland Colony, East Liverpool on November 18th. Twenty-two members were present.

Mrs. William Banfield, president, opened the meeting with remarks on Thanksgiving.

Mrs. Fred Jose and Mrs. Virgil Hart were appointed to a committee to start a "Future Nurses' Club" in Damascus and Salem.

Mrs. William Horger introduced Mrs. Lillian Waggoner of Georgetown, Pa. She presented a delightful musical program entitled "Make Mine Music."

COSHOCTON

Members of the Woman's Auxiliary of the Coshocton County Medical Society entertained their husbands with their annual dinner party November 14 in the home of Dr. and Mrs. Norman L. Wright, Meadowbrook Way. Twenty-two members and guests enjoyed the affair. A social evening followed the dinner.

CUYAHOGA

The interesting and amusing talk, "Tired Mothers Syndrome" by Dr. Leonard Loveshin of the Cleveland Clinic, held the interest of 200 Cuyahoga Auxiliary members at the membership tea. Mrs. F. Ritinger, president, and Mrs. C. A. Colombi, state president-elect, briefed the members on current projects and auxiliary aims.

The annual Chrysanthemum Ball, a benefit, this year supported the "Medical Arts," A-A.M.E.F., R-Recruitment, T-Today's Health and S-Safety. Once again the affair was a success. Mrs. E. W. Gessler was chairman, and Mrs. G. A. Tischler, co-chairman. Five hundred doctors and wives attended the dinner-dance.

Under the direction of Mrs. J. N. Wychgel, Fifth District Director, the auxiliary helped to entertain the members who attended the meeting at the Cleveland College Club. Dr. R. A. Hingson who led the Global Medical Mission Tour to 100 mission hospitals in 30 countries spoke on "Medicine A Universal Language." Each auxiliary wife contributed a carton of medical samples as her ticket of admission to the meeting. The distribution of the drugs (two station-wagon loads) were left to the discretion of the speaker. Mrs. C. H. Bell, state president, and Miss J. Robertson medical writer of the *Cleveland Plain Dealer*, who accom-

panied Dr. Hingson on the tour were guests. The business session included an exchange of ideas on state and national projects.

All doctors' wives who rate an R. N. after names soon will have an opportunity to go on "Special Duty" again, as volunteer nurses in the Red Cross Blood Program. The project sponsored by the auxiliary is in answer to an urgent call for registered nurses at the Blood Center and in Blood-mobile units. Mrs. R. B. Turnbull, chairman of the project, stated that 40 members reported for the orientation course, and she has the promise of many others to help.

ERIE

The Woman's Auxiliary to the Erie County Medical Society met November 3, for tea and a fur style show, at the Sandusky Yacht Club. Invited guests were members of the North Central Ohio Dental Society Auxiliary.

The fur style show was presented by The F. Z. Cikra Co. of Cleveland, with Mrs. Howard Cikra, as moderator. A wide range of prices and styles were shown, and medical Auxiliary members were the models.

Tea was served after the show. Hostesses for the afternoon were Mrs. William Burger, chairman, Mrs. Duane Love, Mrs. Edward Gillette, Jr., Mrs. A. R. Grierson, and Mrs. James Printy.

FAIRFIELD

The Woman's Auxiliary to the Fairfield County Medical Society met at Lancaster Country Club for lunch and a business meeting.

Mrs. G. F. Jones, president of the Auxiliary, presided for the business session.

Mrs. Hubert Amstutz reported that the annual Halloween party for student nurses was held in the home of Mrs. C. R. Reed with Mrs. C. P. Swett and Mrs. Amstutz assisting.

Mrs. Wm. Jasper, recruitment chairman, announced that she had been informed that the Lancaster-Fairfield school of Nursing had been approved for the current year.

A discussion concerning safety in the home and community was led by Mrs. F. W. Jones, Safety chairman for Auxiliary to the Ohio State Medical Association. Various measures of "Improving and Maintaining Safety" were considered by the group.

The committee for the day included Mrs. F. W. Spangler, Mrs. M. E. Nichols and Mrs. Andrew Essman.

KNOX

Final plans for an essay contest open to all Knox County grades 10, 11 and 12 students were

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EXCEPTIONALLY WELL-TOLERATED HEMATINIC
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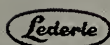
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Thiamine HCl (B ₁)	10 mg.
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completed Wednesday evening, November 19, at the meeting of the Knox County Medical Society Auxiliary in the home of Mrs. O. W. Rapp, Coshocton Rd.

The essay contest, to be jointly sponsored by the society and the auxiliary, will be on the topics, "The Advantages of Private Medical Care," or "The Advantages of the American Free Enterprise System."

During the business session, at which Mrs. George Imhoff, auxiliary president, presided plans were made to serve at the Golden Age meeting in January.

An address, "The History of Bells," was given by Mrs. Ruth Truxall, Mount Vernon High School dramatics and English instructor.

Refreshments were served by the hostess, assisted by the co-hostesses, Mrs. Thomas Prescott and Mrs. Richard Gomer.

MAHONING

A most enjoyable evening was spent October 13 when the Auxiliary members were guests of the Woman's Auxiliary to the Mahoning County Bar Association. The meeting was held in the Court of Appeals room at the County Court House and featured a mock trial put on by men of the Bar Association. The case involved an automobile accident, with the plaintiff, Mr. Wantsit, and the defendant, Mr. Gotit, well represented by able attorneys of the ambulance-chasing variety. The medical testimony was given by Dr. Sluefoot (Dr. L. K. Reed), a "general" specialist of no mean ability, being well versed in the allied fields of orthopedics, gynecology and dermatology. An hilarious time was had by all.

The Auxiliary's benefit dance, held November 22 at Squaw Creek Country Club, was attended by 240 guests. Hors d'oeuvres were served throughout the evening from a candlelighted table featuring a waterfall centerpiece. Dessert and coffee followed after midnight.

A little more than \$700.00 was raised for two very worthy causes, the Nurses Scholarship Fund and the American Medical Education Foundation.

RICHLAND

The Woman's Auxiliary to the Richland County Medical Society met for luncheon at the YMCA on November 3. Thirty-nine members were present.

Various reports were given on the coming election and topics of local interest were also stressed.

Members were urged to have husbands subscribe to *Today's Health*.

Members of the Ways and Means Committee announced they were starting the sale of the Christmas ribbon candy.

Guest speaker, Mr. Harold McCuen, was intro-

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Living accommodations will be available to post-graduate students and their wives in the Cornell Medical Student Residence, Olin Hall, at \$3.00 per person per night.

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Philadelphia 1, Pa.

duced. Mr. McCuen spoke on the mentally retarded child. He invited all auxiliary members to visit his school and also stated that volunteer services were needed.

Forty-two members attended the December 1 annual "Silent Auction," luncheon and bridge at the Women's Club, Mansfield, Ohio.

It was suggested the auxiliary give a permanent gift to the new nurses' residence during "open house." A committee was appointed to take charge of this matter.

A discussion was started regarding recreation equipment for the student nurses. Another committee was appointed to look into this matter and buy the necessary merchandise.

SCIOTO

"Mental health, like charity, begins at home. Its starting point is at the family level, with children," said M. W. McCullough, Ph.D., of Columbus, before 250 men and women at the Portsmouth Receiving Hospital.

Dr. McCullough, chief psychologist for the State Division of Mental Hygiene, and president of the Ohio Psychological Association, was the guest speaker at a public meeting sponsored by the woman's auxiliary to the Scioto County Medical Society in co-operation with Dr. T. A. McMahon, superintendent of the Receiving Hospital.

Following the doctor's informative talk refreshments were served and a tour of the hospital was conducted by the hospital's volunteer workers.

STARK

This year the auxiliary is celebrating its 30th anniversary. A program was held November 18 at the St. Francis Hotel in Canton to honor the 20 active charter members. Mrs. P. E. Smith was chairman for the day assisted by Mrs. K. E. Liber. Congratulations and an arrangement of pink carnations were received from the Society.

Mrs. Stanley Benjamin is chairman for *Today's Health*. A goal of the auxiliary is to have a copy in every doctor's waiting room.

The Stark County Medical Society made a gift of \$272.98 for the purpose of supplying reference material to the libraries of 22 high schools in this county and also the public library on the topic

"The Advantages of Private Medical Care." This material will be used in relation to the essay contest.

Three new "Future Nurses Clubs" have been added to the group sponsored. They are the Perry, Navarre, and Massillon clubs. Mrs. Lloyd Dowell is chairman.

SUMMIT

A dessert and coffee meeting was held by the Woman's Auxiliary to the Summit County Medical Society on December 2 in the auditorium of the Akron Art Institute. Mr. LeRoy Flint, director of the Akron Institute, spoke on "Madonnas." As the guests arrived, they were greeted around a holiday punch bowl by the hospitality committee, Mrs. J. C. Woodbury, chairman, and Mrs. A. A. Brown, co-chairman. Music for the festive occasion was provided by the Madrigal Singers from Buchtel High School under the direction of Mr. Charles Kidder. Wives of residents and interns from the area hospitals were the guests of the auxiliary.

TRUMBULL

The Auxiliary to the Trumbull County Medical Society met on November 20 for luncheon at the Cafe 422. Members of the Corydon-Palmer Dental Society were guests. In the absence of the President, Mrs. John Grima, the President-Elect, Mrs. Bruce Brown, conducted the short business meeting.

Mrs. John Schlect asked the Auxiliary members to help the Mental Health Society by contributing gifts for the "forgotten patients" in our Mental Institutions. A forgotten patient is one who has had no visit from a friend or relative for over a year.

Mrs. D. H. Chickering introduced the speaker from Youngstown, Mrs. E. J. Kidd. Her subject, "Handwriting Analysis," she stated, was not fortune-telling, but a science.

Dr. T. Brent Wayman, director of the Division of Urology, University of Cincinnati, has been named president-elect of the North Central Section of the American Urological Association. The Section includes about 600 physician specialists from nine states and the Province of Manitoba, Canada.

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March of Inflation . . .

What It Is and Its Evils Are Discussed by Executive of National Organization; What Individuals Can Do About It Are Also Outlined

ADDRESSING a group of trade association executives at Granville Inn not long ago, Glenn B. Sanberg, Washington, D. C., executive vice-president of the American Society of Association Executives, stated that the most important trend in government today, and one which affects all business and every individual citizen is the growing and relentless march of inflation, adding that every citizen should take a look at what's happening and then determine for himself whether it is his business or not.

"What is inflation?" asked Mr. Sanberg. "Inflation is simply the decline of purchasing power of the dollar. Let me illustrate.

The Babe Ruth Case

"In 1932 Babe Ruth signed a contract back with the Yankees at a salary of \$100,000 a year. The tax on the \$100,000 was \$32,000. That was in 1932. Babe Ruth's take-home pay was \$68,000. In 1958 Ted Williams signed a similar contract with the Boston Red Sox. His salary was \$100,000. The tax on that salary is \$68,000, and his take-home pay is only \$32,000. Thus you will see that in twenty-five years the tax has replaced the take-home pay. But something even worse has happened—the purchasing power of the dollars which represent the take-home pay has decreased catastrophically. If Ted Williams were to receive in his contract from the Boston Red Sox the same value in purchasing power which Babe Ruth received in 1932, Ted Williams' salary would have to be—now hold on to your seats—\$934,000!

"That's inflation.

"This persistent, continual erosion of the value of the American dollar will continue to wreak untold havoc with the economy of America unless concerted and dedicated action is taken by responsible business and professional men in concert.

Must Have Crusade

"Instead of wasting our time and energy in minor competitive warfare, voluntary associations would be immeasurably better off if it were to formally organize as a matter of national policy, to crusade against inflation. Inflation is eating away at our lifeline of profits which feed our free enterprise institutions.

"One of the sad commentaries of this trend is that blind businessmen are attempting to make a fast buck at the expense of future America.

A Good Illustration!

An excellent illustration of the subject of the accompanying article are the following excerpts from an article in the Newsletter of the Hospital Care Corporation (Blue Cross) of Cincinnati:

"19 years ago this month, Southwestern Ohio Blue Cross paid its first hospital bill—the 10-day stay cost \$70.10.

"19 years later, after paying 2,116,942 other hospital bills, Blue Cross paid still another bill for a similar illness. Even with complications, the length of stay was only 12 days . . . but the cost was \$642.25 for the 1958 bill . . .

"Average daily cost was \$7.00 in 1939; \$53.00 in 1958.

"Ninety per cent of the drugs needed in the 1958 case were not even available in 1939.

"A recent advertisement in the Wall Street Journal typifies what I am talking about. This advertisement reads:

"Buy this Florida Motel, grossing nearly \$70,000, a year in Room Rentals for \$250,000. Pay only \$72,000 down. Pay the rest in inflated dollars over a twenty year period.—This is your chance to take advantage of the cheap dollars of the future!"

"Yes, the catastrophic effects of inflation is the business of American business. Sales campaigns, pitched to the unsound theory of "buy now before prices go up even more" only feed the flames of inflation.

Vulnerable Unless We Act

"Until we establish a national policy, forthright, honest, and courageous against this greatest economic evil which has beset our times, the very foundations of free enterprise may be shaken, and we may be laid vulnerable to the arch enemies of the American way.

"I hear many voices asking when we will become involved in a Third World War? I hear it everywhere. The answer is, we are in a Third World War now—a World War of Ideas, and unless America takes a better look than a bug's-eye view of the future we are in for real trouble.

"This is not idle talk. It can be done, but it



running noses and open stuffed noses orally

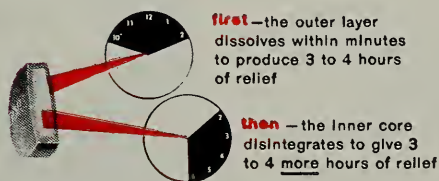
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- in nasal and paranasal congestion
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safer and more effective than topical medication

- reaches *all* respiratory membranes systemically
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Relief with Triaminic is prompt and prolonged because of this special timed-release action . . . beneficial effect starts in minutes, lasts for hours.



Each TRIAMINIC Tablet provides:

Phenylpropanolamine HCl . . . 50 mg.
Pheniramine maleate . . . 25 mg.
Pyrilamine maleate . . . 25 mg.

One-half of this formula is in the outer layer, the other half is in the core.

Dosage: One tablet in the morning, mid-afternoon and in the evening, if needed.

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Also available: For the occasional patient who requires only half dosage: timed-release TRIAMINIC JUVELETS. Each Juvelet is equivalent to $\frac{1}{2}$ of a Triaminic Tablet.

For those patients who prefer liquid medication: TRIAMINIC SYRUP. Each 5 ml. tsp. of this palatable syrup is equivalent to $\frac{1}{4}$ of a Triaminic Tablet.

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will only be done by the efforts of organized groups within the free enterprise system.

"West Germany has done it, and has demonstrated beyond all possible doubt with her dynamic economic revival, the greatest of any nation since World War II. It is possible to have prosperity without inflation when there is strong leadership steering an anti-inflation course, and when there is a national attitude, consciously unified in opposition to inflation.

"You may say, well, those are high sounding words, Sanberg, but what can we do about it?

What Can We Do?

"Well, there are many things we can do. 1. Make certain that business, the professions which we represent take a definite and firm stand against higher pricing.

"2. We can demand and get more, not less production from our employees. Inflation starts on Main Street, not in the steel mills.

"3. We can insist that our lawmakers take a similar step as a matter of public financial policy. Let's call on the President of the United States to come out forthrightly as he did not do this year calling on Congress to adopt a resolute and positive anti-inflation policy.

"If the President or Congress refuses to take the leadership in this war to save economic America then we will have no recourse but to take to the ballot box and see to it that leadership takes over in the White House and in the Congress to assume these responsibilities for all America's future.

"Veto of a few pork barrel bills is not enough.

"Yes, inflation is the job of free enterprise, and we had better get on with the task."

Illness and Injury Put 20-Day Gap in Average Year of Activity

Illness or injury caused the American people to stay home from work, stay in bed, or otherwise cut down on normal activities for about 3 billion 400 million days during the fiscal year ending June 30, 1958.

This total of disability, which averaged 20 days per person per year, is reported in the first U. S. National Health Survey publication to provide figures from a full year of nationwide household interviewing.

The report gives selected statistics on acute conditions, chronic conditions, persons injured in accidents, physician visits, dental visits, and disability.

Acute illnesses, including acute respiratory conditions, totaled 437,900,000, or an average of about 2.6 per person. How many of these illnesses

Cook County Graduate School of Medicine

INTENSIVE POSTGRADUATE COURSES

STARTING DATES — EARLY 1959

SURGERY—Surgical Technic, two weeks, Feb. 16, Mar. 2. Surgery of the Colon & Rectum, one week, Mar. 2, Apr. 6. Fractures & Traumatic Surgery, two weeks, Mar. 9. Treatment of Varicose Veins, two days, Mar. 2, Apr. 6. American Board Review Course (Part I), two weeks, Apr. 6. Blood Vessel Surgery, one week, Feb. 16. General Surgery, one week, Feb. 9.

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, Feb. 9, Mar. 16. Vaginal Approach to Pelvic Surgery, one week, Feb. 2, Mar. 9. General & Surgical Obstetrics, two weeks, Feb. 23, Mar. 30.

MEDICINE—Electrocardiography, two-week basic course, Mar. 16. Gastroscopy & Gastroenterology, two weeks, Mar. 2. American Board Review Course (Part II), to be announced.

UROLOGY—Two-Week Intensive Course, Apr. 27. Ten-Day Practical Course in Cystoscopy, by appointment.

RADIOLOGY—Diagnostic X-Ray, two weeks, Mar. 2, Apr. 27. Clinical Uses of Radioisotopes, two weeks, May 4.

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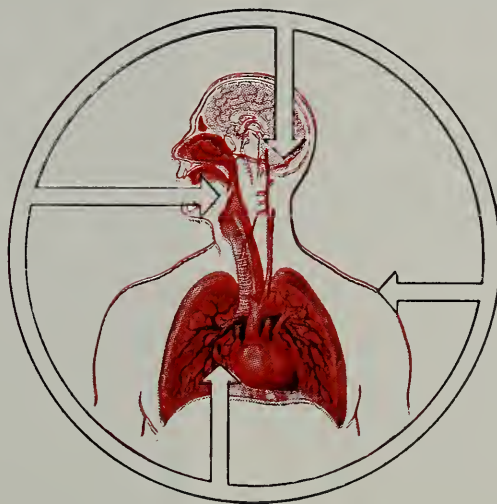
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Provides Triaminic for more complete and more effective relief from nasal and paranasal congestion because of systemic transport to *all* respiratory membranes—without drawbacks of topical therapy.[†]

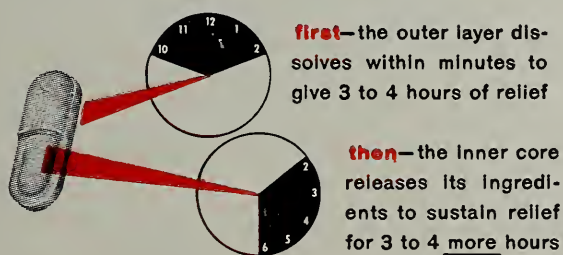
Provides well-tolerated APAP (N-acetyl-p-aminophenol) for prompt and effective analgesic and antipyretic action to make the patient more comfortable.

Provides Dormethan (brand of dextromethorphan HBr) for non-narcotic anti-tussive action on the cough reflex center in the medulla—as effective as codeine but without codeine's drawbacks.

Provides terpin hydrate, classic expectorant to thin inspissated mucus and help the patient clear the respiratory passages.

[†]Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. Fabricant, N. D.: E. E. N. T. Monthly 37:460 (July) 1958. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

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also available for those patients who prefer liquid medication: Tussagesic suspension

Each TUSSAGESIC tablet provides:

TRIAMINIC® 50 mg.

(phenylpropanolamine HCl . . . 25 mg.

pheniramine maleate . . . 12.5 mg.

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Dormethan




(brand of dextromethorphan HBr) 30 mg.

Terpin hydrate 180 mg.

APAP (N-acetyl-p-aminophenol) . . 325 mg.

Dosage: One tablet in the morning, midafternoon and in the evening, if needed.

Tussagesic^{*} *timed-release tablets*

*Contains TRIAMINIC to  running noses   and open stuffed noses orally

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were caused by Asian influenza is not known. However, the report shows that acute respiratory conditions caused an average of about seven days of restricted activity per person, including days in bed or days lost from work or school.

About 47,000,000 persons were injured seriously enough during the year to cause them to restrict their activities for a day or more or seek medical attention, the report shows. Injuries caused 424,100,000 days of restricted activity, or 2.5 days per person.

The importance of chronic conditions is indicated by the fact that circulatory diseases alone were the cause of 484,200,000 days of restricted activity, which would be the equivalent of about 2.9 days per person. The circulatory diseases rank higher than any other group of chronic conditions in this respect.

The publication, "Selected Survey Topics, United States, July 1957 - June 1958," is Public Health Service Publication No. 584-B5. Copies are for sale by the Superintendent of Documents, Government Printing Office, Washington 25, D. C., at 40 cents a copy.

Doctors' Nurses Organization Branded Promotional Scheme

Ohio physicians and their office assistants who have been receiving letters from the American Registry of Doctors' Nurses are advised to ignore such communications.

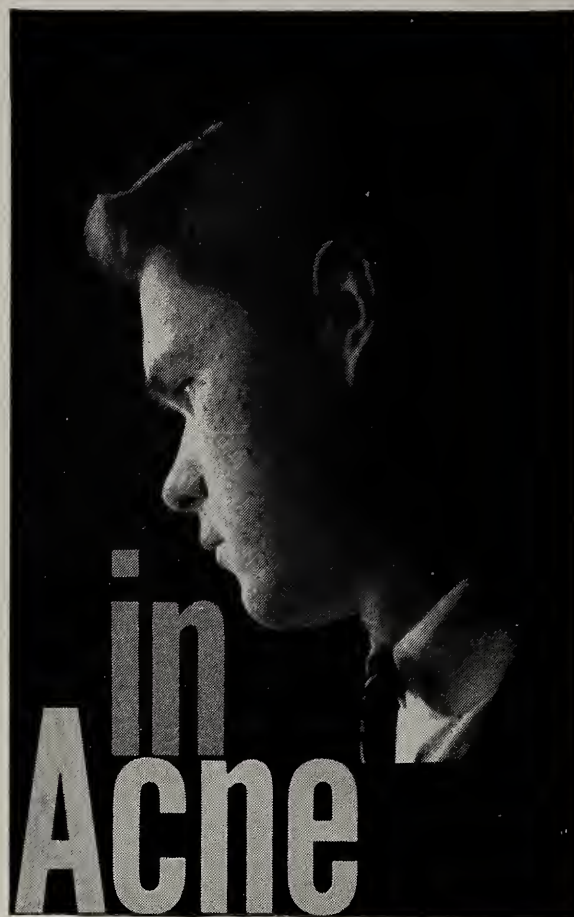
Physicians inquiring of AMA about American Registry of Doctors' Nurses, Mariana, Fla., are being told that the Florida attorney general has ruled the Registry is in violation of the Nursing Practice Act of Florida.

Inquirers also are told that American Nurses' Association reports Registry is "commercial enterprise . . . not recognized by professional associations in the health field," and that AMA endorses the objectives of the American Association of Medical Assistants.

The Ohio State Medical Association has endorsed and supports the activities of the Ohio State Society of Medical Assistants.

Physicians or their employees receiving letters or literature from the American Registry of Doctors' Nurses are requested to send such material to the OSMA Columbus Office so it can be turned over to the State Nurses Board for investigation and action.

Dr. Herman Bearzy, Dayton, was named to the Executive Board of the American Institute of Ultrasonics in Medicine at that organization's interim meeting.



"No patient failed to improve."

*pHisoHex washing added to standard treatment in acne produced results that "... far excelled... results with the many measures usually advocated."*¹

pHisoHex maintains normal skin pH, cleans and degerms better than soap. In acne, it removes oil and virtually all skin bacteria *without scrubbing*.

For best results—four to six washings a day with pHisoHex will keep the acne area "surgically" clean.

1. Hodges, F. T.: *GP* 14:86, Nov., 1956.

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(Continued on next page)

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Woman's Auxiliary Advisory Committee—C. L. Pitcher, Portsmouth, Chairman; Carl A. Gustafson, Youngstown; H. T. Pease, Wadsworth.

DELEGATES AND ALTERNATES

Delegates and Alternates to the American Medical Association—Paul A. Davis, Akron; Edmond K. Yantes, Wilmington, alternate; Charles L. Hudson, Cleveland; H. T. Pease, Wadsworth, alternate; Carl A. Lincke, Carrollton; Robert S. Martin, Zanesville, alternate; Carl S. Mundy, Toledo; Paul F. Orr, Perrysburg, alternate; L. Howard Schriver, Cincinnati; Charles A. Sebastian, Cincinnati, alternate; C. C. Sherburne, Columbus; Richard L. Meiling, Columbus, alternate; George A. Woodhouse, Pleasant Hill; R. Dean Dooley, Dayton, alternate; Herbert B. Wright, Cleveland; Fred W. Dixon, Cleveland, alternate.

COUNTY SOCIETIES' OFFICERS AND MEETING DATES

FIRST DISTRICT

ADAMS—Sam C. Clark, President, Cherry Fork; Hazel L. Sproull, Secretary, West Union. 3rd Wednesday, April, June, August, October, December.

BROWN—Vytautas Karoblis, President, 410 Main St., Ripley; Charles William Hannah, Secretary, Sardinia. 1st Sunday, monthly.

BUTLER—Clyde G. Chamberlin, President, 300 Rentschler Bldg., Hamilton; Mr. Charles G. Greig, Executive Secretary, 110 N. Third St., Hamilton. 4th Wednesday of alternate months.

CLERMONT—Richard D. Carr, President, Williamsburg; Harry M. Breuer, Secretary, New Richmond. Third Wednesday, monthly.

CLINTON—Roy D. Goodwin, President, Wilmington; H. Richard Bath, Secretary, Wilmington. 2nd Tuesday, monthly.

HAMILTON—J. Robert Hudson, President, 152 E. Fourth St., Cincinnati 2; Mr. Edward F. Willenborg, Executive Secretary, 152 E. Fourth St., Cincinnati 2. 3rd Tuesday, monthly, September through May.

HIGHLAND—J. Martin Byers, President, 316 Midway, Greenfield; Kenneth Lyle Upp, Secretary, 136 S. Washington St., Greenfield. 1st Wednesday, monthly.

WARREN—Howard G. Berninger, President, Lebanon; D. Paul Ward, Secretary, Pleasant Plain. 2nd Tues., monthly.

SECOND DISTRICT

CHAMPAIGN—John K. Pond, President, Urbana; William Pudvan, Secretary, Mechanicsburg. 2nd Wednesday, monthly.

CLARK—Elliott W. Schilke, President, Springfield; Martin J. Cook, Secretary, Springfield.

DARKE—V. Ray Boli, President, Greenville; Emmett W. Arnold, Secretary, Greenville. 3rd Tuesday, monthly, except June, July, August, December.

GREENE—Paul C. Vernier, President, 67 Xenia Drive, Fairborn; Quinten L. Erd, Secretary, S. Limestone, Jamestown. 2nd Thursday, monthly.

MIAMI—William W. Weis, President, 404 W. Wayne St., Piqua; John W. Gallagher, Acting Secretary, 407 W. High St., Piqua. 1st Friday, monthly.

MONTGOMERY—Albert V. Black, President, Centerville; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Building, Dayton 2. 1st Friday, Jan., Feb., March, April, May and November; 1st Wednesday, June, October and December.

PREBLE—E. P. Tritschuh, President, 309 E. Main St., Lewisburg; Birna R. Smith, Secretary, 203 Commerce St., Lewisburg.

SHELBY—Clayton B. Conover, President, 316 S. Main Ave., Sidney; Ned A. Smith, Secretary, 739 Spruce St., Sidney. 1st Tuesday, monthly.

THIRD DISTRICT

ALLEN—Roger L. Tecklenberg, President, 700 Cook Tower, Lima; Thomas D. Allison, Secretary, 401 Steiner Bldg., Lima. 3rd Tuesday, monthly, except June, July, August.

AUGLAIZE—Robert J. Herman, President, Wapakoneta; Robert S. Oyer, Secretary, Wapakoneta.

CRAWFORD—Donald R. Wenner, President, 117 S. Poplar St., Bucyrus; Arnold Eicens, Secretary, 406 S. Sandusky St., Bucyrus. 3rd Thursday, monthly.

HANCOCK—Frank M. Wiseley, President, Findlay; Benjamin H. Saunders, Jr., Secretary, Findlay. 3rd Tuesday, monthly.

HARDIN—Louis A. Black, President, Kenton; William F. Binkley, Secretary, Kenton. 2nd Tuesday, monthly.

LOGAN—Frederick W. Kaylor, President, Bellefontaine; Charles A. Browning, Jr., Secretary, Bellefontaine. 1st Friday, monthly.

MARION—Daniel M. Murphy, President, Marion; James A. Schuler, Secretary, Marion. 1st Tuesday, monthly, except June, July, August.

MERCER—Donald R. Fox, President, Celina; Louis J. Finkelmeier, Secretary, Celina.

COUNTY SOCIETIES' OFFICERS AND MEETING DATES (Continued)

SENECA—Thomas W. Watkins, President, 34 W. Market St., Tiffin; Robert R. Schwalenberg, Secretary, 34 W. Market St., Tiffin. 3rd Tuesday, every other month.

VAN WERT—Jack H. Cox, President, 301 N. Washington St., Van Wert; Ralph E. Razor, Jr., Secretary, 507 S. Washington St., Van Wert.

WYANDOT—Richard L. Garster, President, Upper Sandusky; Allen F. Murphy, Secretary, Upper Sandusky. 2nd Tues.

FOURTH DISTRICT

DEFIANCE—William S. Busted, President, Defiance; Gerald A. Huber, Secretary, Defiance. 1st Saturday, monthly.

FULTON—Edwin R. Murbach, President, 224 N. Defiance St., Archbold; Robert A. Ebersole, Secretary, 203 DeGroff Ave., Archbold. 2nd Tuesday, monthly.

HENRY—Edwin C. Winzeler, President, 812½ N. Perry St., Napoleon; Thomas F. Tabler, Secretary, 332 Railway Ave., Holgate. 1st Tuesday, monthly.

LUCAS—Harvey C. Gunderson, President, Toledo; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Blvd., Toledo 10. 3rd Tuesday, monthly.

OTTAWA—Cyrus R. Wood, President, 115 Madison St., Port Clinton; Robert W. Minick, Secretary, 124½ W. Water St., Oak Harbor. 2nd Thursday, monthly.

PAULDING—Edythe C. Pritchard, President, Paulding; D. E. Farling, Secretary, Payne. 3rd Wednesday, monthly.

PUTNAM—Walter E. Martin, President, 135 N. High St., Columbus Grove; Will W. Moody, Secretary, Vaughnsville. 1st Tuesday, monthly.

SANDUSKY—R. Allen Eyestone, President, Gibsonburg; Paul E. Burson, Secretary, Cor. Southwest & Center St., Bellevue. 3rd Wednesday, monthly.

WILLIAMS—Robert W. Dilworth, President, Main St., Montpelier; E. K. Bell, Secretary, P. O. Box 466, Bryan. Monthly meeting date varies.

WOOD—Stewart J. Smith, President, Bowling Green; Richard L. Pearse, Secretary, Bowling Green.

FIFTH DISTRICT

ASHTABULA—Lewis H. Roth, President, 80 S. Broadway, Geneva; Albin F. Urankar, Secretary, Ashtabula Gen. Hospital, Ashtabula.

CUYAHOGA—Chester R. Jablonoski, President, Cleveland Mr. Robert A. Lang, Executive Secretary, 2009 Adelbert Road, Cleveland 6. 2nd Tuesday, monthly.

GEAUGA—George Dandalides, President, Chardon Medical Center, Chardon; Alton W. Behm, Secretary, 112 South St., Chardon. 2nd Friday, monthly.

LAKE—Richard W. McBurney, President, 124 S. St. Clair St., Painesville; Mrs. Owen A. McLaren, Executive Secretary, 1051 Cadle Ave., Mentor.

SIXTH DISTRICT

COLUMBIANA—Roy C. Costello, President, East Liverpool; William J. Horger, Secretary, East Liverpool.

MAHONING—M. W. Neidus, President, 318 Fifth Ave., Youngstown; Mr. Howard C. Rempes, Jr., Executive Secretary, 245 Bel-Park Bldg., 1005 Belmont Ave., Youngstown 4. 3rd Tuesday, monthly.

PORTAGE—Charles C. Whitsett, President, Robinson Memorial Hospital, Ravenna; Don P. VanDyke, Secretary, 607 E. Main St., Kent. 3rd Tuesday, monthly.

STARK—John R. Seesholtz, President, 1645 Cleveland Ave., N. W., Canton; Mr. E. M. Sprunger, Executive Secretary, 405 Fourth Street, Canton 2. 2nd Thursday, monthly, except May, June, July, August and September.

SUMMIT—Donald I. Minnig, President, 640 W. Market St., Akron; Mr. S. H. Mountcastle, Executive Secretary, 437 Second National Building, Akron. 1st Tuesday, monthly, September through June.

TRUMBULL—Paul E. Noonan, President, 238 N. Park Ave., Warren; Ralph H. Jamison, Secretary, 197 W. Market St., Warren. 3rd Wednesday, monthly.

SEVENTH DISTRICT

BELMONT—John A. Brown, President, Morristown; Bertha M. Joseph, Secretary, 100 S. Fourth St., Martins Ferry. 3rd Thursday, monthly.

CARROLL—Joseph D. Stires, President, Malvern; Samuel L. Weir, Secretary, Minerva. 1st Thursday, monthly.

COSHOCOTON—Lewis E. Smith, Jr., President, 729 Main St., Coshocot; Harold W. Lear, Secretary, 110 N. Seventh St., Coshocot. 2nd Tuesday, monthly.

HARRISON—Elias Freeman, President, 264 S. Main St., Cadiz; Janis Trupovnieks, Secretary, High St., Box 366, Hopedale.

JEFFERSON—Carl F. Goll, President, Steubenville; Frances J. Shaffer, Secretary, Toronto. 3rd Tuesday, monthly.

MONROE—Byron Gillespie, Secretary, South Main Street, Woodsfield.

TUSCARAWAS—Chester A. Bennett, President, 533 Wooster Ave., Dover; George D. Woodward, Secretary, 201 Boulevard, Dover. 2nd Thursday, monthly.

EIGHTH DISTRICT

ATHENS—T. J. Najm, President, 422 W. Washington St., Nelsonville; Charles R. Hoskins, Secretary, Security Bank Bldg., Athens. 2nd Tuesday, monthly.

FAIRFIELD—Lloyd L. Kersell, President, 130 Union St., Lancaster; Arthur B. VanGundy, Secretary, 843 N. Columbus St., Lancaster. 2nd Tuesday, monthly.

GUERNSEY—Jesse B. Kellum, President, 840 Wheeling Ave., Cambridge; Thomas D. Swan, Secretary, 651 Wheeling Ave., Cambridge. 1st Thursday, monthly.

LICKING—Kurt J. Fleisch, President, 125 Hudson Ave., Newark; Jay Ross Wells, Secretary, 375 Granville St., Newark. Last Tuesday, monthly.

MORGAN—A. H. Whitacre, President, Chesterhill; C. E. Northrup, Secretary, McConnelsville. Called Meetings.

MUSKINGUM—J. Herbert Bain, President, 67 W. Main St., New Concord; William A. Knapp, Secretary, 1025 Maple Ave., Zanesville. 1st Tuesday, monthly.

NOBLE—Charles F. Thompson, President, Caldwell; E. G. Ditch, Secretary, Caldwell. 1st Tuesday, monthly.

PERRY—Charles E. Bope, President, Somerset; O. D. Ball, Secretary, 203 N. Main St., New Lexington. Called meetings.

WASHINGTON—Richard R. Hille, President, Marietta; Roy M. Meredith, Secretary, Marietta. 2nd Wednesday, monthly.

NINTH DISTRICT

GALLIA—Thomas W. Morgan, President, Holzer Hospital, Gallipolis; Norman W. Pinschmidt, Secretary, Gallipolis Clinic, 52 State Street, Gallipolis. 3rd Thursday, monthly.

HOCKING—George B. Watson, President, Box 296, Adelphi; Howard M. Boocks, Secretary, Court House, Logan. Indefinite meeting dates.

JACKSON—Tom Washam, President, 35 Vaughn St., Jackson; Brinton J. Allison, Secretary, 267 Ralph St., Jackson. Called meetings.

LAWRENCE—Gerard C. Geswein, President, 1626 S. Sixth St., Ironton; George Newton Spears, Secretary, 2213 S. Ninth St., Ironton. Monthly meetings on call.

MEIGS—Joseph J. Davis, President, Middleport; Charles J. Mullen, Secretary, Pomeroy.

PIKE—Paul H. Jones, President, Stockdale; George W. Cooper, Secretary, Piketon. 1st Tuesday, monthly.

SCIOTO—Ralph W. Lewis, President, 1025 Ninth St., Portsmouth; Carl H. Laestar, Secretary, 2829 Gallia St., Portsmouth. 2nd Monday, monthly.

VINTON—Richard E. Bullock, President, McArthur; H. D. Chamberlain, Secretary, McArthur.

TENTH DISTRICT

DELAWARE—Max W. Livingston, President, 28 North Vernon, Sunbury; Edward C. Jenkins, Secretary, c/o Mrs. Mabel Barrett, Jane M. Case Hospital, Delaware. 3rd Tuesday, monthly.

(Continued on Next Page)

COUNTY SOCIETIES' OFFICERS AND MEETING DATES (Continued)

FAYETTE—Robert U. Anderson, President, Washington C. H.; Philip E. Binzel, Secretary, Washington C. H. 2nd Tuesday, monthly.

FRANKLIN—James L. Henry, President, 244 E. Park St., Grove City; Mr. William Webb, Executive Secretary, 79 East State Street, Columbus 15. Meetings in January, February, March, May, September, November and December.

KNOX—James C. McLarnan, President, Mount Vernon; Clinton W. Trott, Secretary, Mount Vernon. Quarterly meetings.

MADISON—William T. Bacon, President, 40 E. First St., London; Paul G. H. Wolber, Secretary, 40 E. First St., London. 2nd Wednesday, monthly.

MORROW—Francis W. Kubbs, President, Mt. Gilead; Frank H. Sweeney, Secretary, Mt. Gilead. 1st Tuesday, monthly.

PICKAWAY—Henry H. Swope, President, 233 N. Court St., Circleville; Edward L. Montgomery, Secretary, 108 Seyfert Ave., Circleville. 1st Friday, monthly.

ROSS—Robert E. Quinn, President, 30 N. Walnut St., Chillicothe; G. Howard Wood, Secretary, 134 W. Main St., Chillicothe. 1st Thursday, monthly.

UNION—Paul Richard Zaugg, President, Marysville; May B. Zaugg, Secretary, Marysville. 2nd Tuesday, monthly.

ELEVENTH DISTRICT

ASHLAND—R. Lee Schafer, President, 404 Samaritan Avenue, Ashland; Wayne C. Smith, Secretary, 140 Claremont Ave., Ashland. 1st Friday, monthly, except July, August.

ERIE—William E. Birmingham, President, Sandusky; Edward Gillette, Secretary, Sandusky. Last Thursday, monthly.

HOLMES—Clyde Bahler, President, Walnut Creek; Luther W. High, Secretary, R. F. D. 4, Millersburg. 2nd Wednesday, monthly.

HURON—Walter A. Drury, President, Box 269, Willard; John V. Emery, Secretary, Box 269, Willard. 2nd Wednesday, March, June, September and December.

LORAIN—Denis A. Radefeld, President, 209 Sixth St., Lorain; Mrs. C. Ruth Zealley, Executive Secretary, 311 Elyria Block, Elyria. 2nd Tuesday, monthly.

MEDINA—Robert E. Smith, President, 403 East Liberty St., Medina; William G. Halley, Secretary, 115 Bank Street, Lodi. 3rd Thursday, monthly.

RICHLAND—Riley E. Frush, President, 36 S. Mulberry St., Mansfield; James O. Ludwig, Secretary, 336 Sturges Ave., Mansfield. 3rd Thursday, monthly.

WAYNE—James E. Robertson, President, Wooster; R. E. Schulz, Secretary, Wooster. 2nd Wednesday, monthly.

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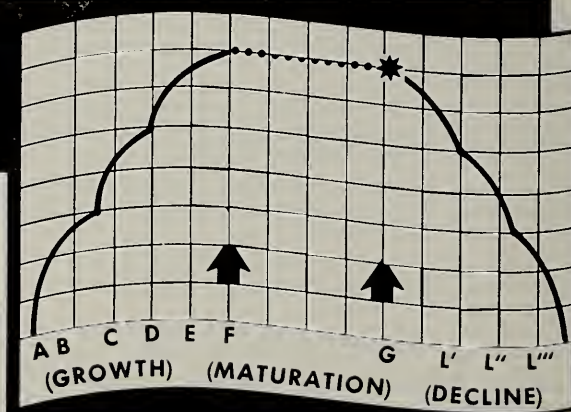
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*Chappel, C.C., J.A.M.A., 162: 1414, (Dec. 8) 1956

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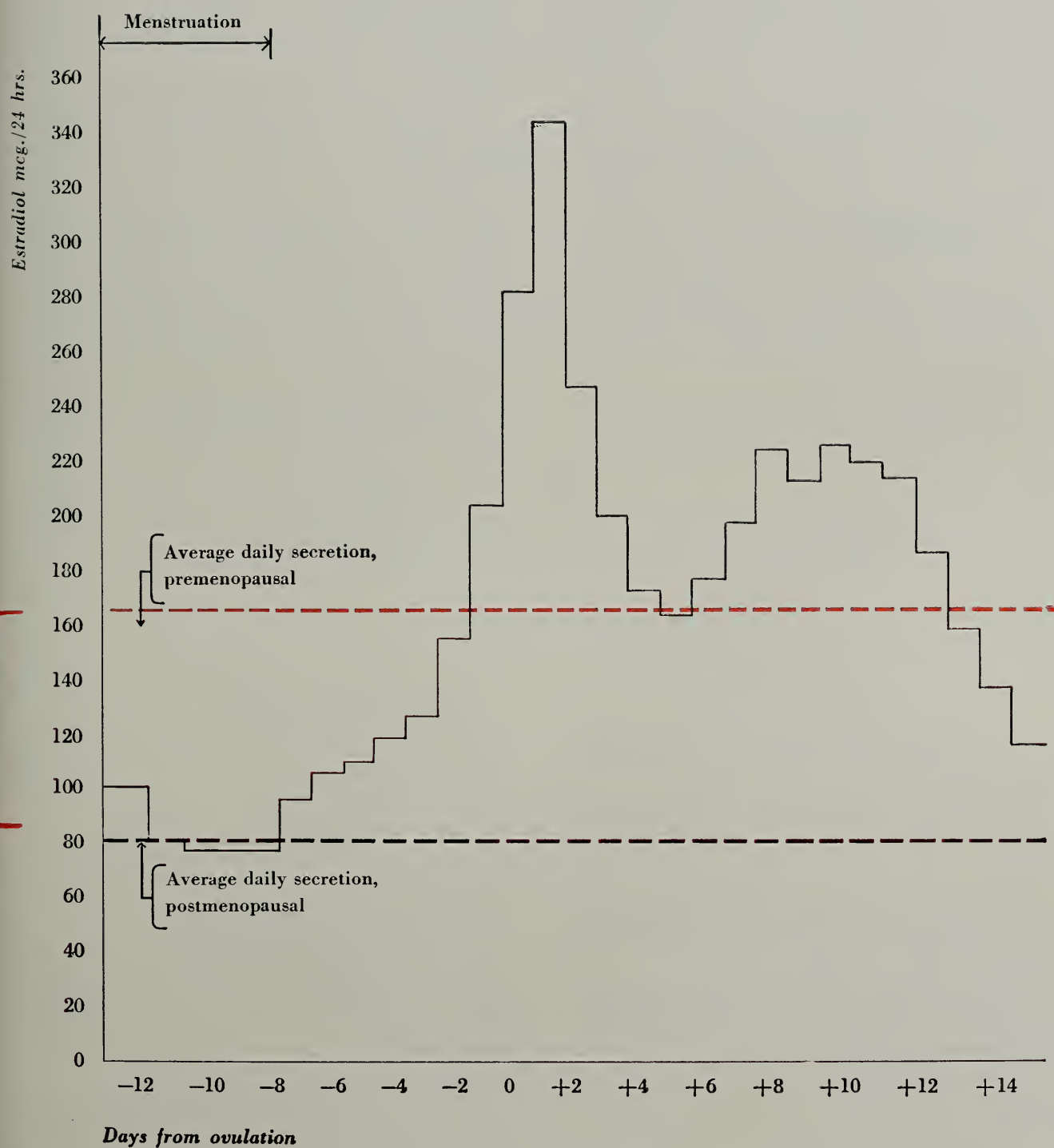
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The Physician's Bookshelf

(Books received from publishers. *The Journal* is not obligated to list herein every book received. It will try to list those which appear to be of greatest interest.)

* * *

Rehabilitation Medicine, by Howard A. Rusk, M. D. (\$12.00, *The C. V. Mosby Co., St. Louis 3, Missouri.*)

Head Injuries; Mechanisms, Diagnosis and Management, by E. S. Gurdjian, M. D., and J. E. Webster, M. D. (\$14.00, *Medical Book Department, Little, Brown and Co., Boston 6, Mass.*)

Eye Surgery, by H. B. Stallard, M. D., (\$18.00, Third Edition, *The Williams and Wilkins Co., Baltimore 2, Md.*, exclusive U. S. distributors.)

Human Protein Requirements and Their Fulfillment in Practice, by J. C. Waterlow and Joan M. L. Stephen. (\$2.00, *Columbia University Press, New York 27, N. Y.*)

Handbook of Medical Treatment, by Milton J. Chatton, M. D., Sheldon Margen, M. D., and Henry Brainerd, M. D. (\$3.50, *Lange Medical Publications, P. O. Box 1215, Los Altos, Calif.*)

The Low-Fat Way to Health and Longer Life; The Complete Guide to Better Health Through Automatic Weight Control, Modern Nutritional Supplements, and Low-Fat Diet, by Lester M. Morrison, M. D. (\$4.95, *Prentice-Hall, Inc., Englewood Cliffs, New Jersey.*)

Will My Baby Be Born Normal; Public Affairs Pamphlet No. 272, by Joan Gould. (25¢, *Public Affairs Committee, 22 E. 38th Street, New York 16, N. Y.*)

First Aid For Your Infant and Child, by Eric Northrup, M. D. (\$3.95, *Henry Holt and Company, Inc., New York 17, New York.*)

Water and Electrolyte Metabolism in Relation to Age and Sex, by G. E. W. Wolstenholme and Cecilia M. O'Connor. (\$8.50, Volume 4, *Little, Brown and Co., Boston, Mass.*)

Neurological Basis of Behaviour, by G. E. W. Wolstenholme and Cecilia M. O'Connor. (\$9.00, *Little, Brown and Co., Boston, Mass.*)

Sex and the Adolescent, by Maxine Davis. (\$5.00, *The Dial Press, Inc., New York 16, New York.*)

Arab Unity; Hope and Fulfillment, by Dr. Fayez A. Sayegh, Ph. D. (\$4.00, *The Devin-Adair Co., New York 10, N. Y.*)

Pathophysiology in Surgery, by James D. Hardy, M. D. (\$19.00, *The Williams and Wilkins Co., Baltimore 2, Md.*)

Human Biochemistry, by Israel S. Kleiner and James M. Orten. (\$9.00, Fifth edition, *The C. V. Mosby Co., St. Louis 3, Mo.*)

The Brooks Legend, by William Donohue Ellis. (\$4.95, *Thomas Y. Crowell Co., New York 16, N. Y.*)

Poisoning; A Guide to Clinical Diagnosis and Treatment, by W. F. von Oettingen, M. D. (\$12.50, Second edition, *W. B. Saunders Co., Philadelphia, Pa.*)

Schizophrenia, by Manfred Sakel, M. D. (\$5.00, *Philosophical Library, Inc., New York 16, New York.*)

Heredity of the Blood Groups, by Alexander S. Wiener, M. D., and Irving B. Wexler, M. D. (\$6.00, *Grune & Stratton, Inc., New York 16, New York.*)

Antibiotics Annual 1957-1958, by Henry Welch, Ph. D., and Felix Marti-Ibanez, M. D. (\$12.00, *Interscience Publishers, New York 1, New York.*)

The Care of the Geriatric Patient, by E. V. Cowdry, Ph. D. (\$8.00, *The C. V. Mosby Co., St. Louis 3, Mo.*)

What We Do Know About Heart Attacks, by John W. Gofman, M. D. (\$3.50, *G. P. Putnam's Sons, New York 16, N. Y.*)

The Nonoperative Aspects of Pediatric Surgery, by Ross Laboratories: Report of the Twenty-seventh Ross Pediatric Research Conference. (Apply, *Ross Laboratories, Columbus 16, Ohio.*)

Food and You, by Edmund Sigurd Nasset, B. A., Ph. D. (\$1.25, Second edition, No. 201, *Barnes & Noble, Inc., New York 3, N. Y.*)

Emergency War Surgery: NATO Handbook, by John Boyd Coates, Jr., editor in chief. (\$2.25, *Department of the Army Historical Unit, U. S. Army Medical Service, Walter Reed Army Medical Center, Washington 12, D. C.*)

The Doctor Business, by Richard Carter. (\$4.00, *Doubleday & Co., Inc., New York 22, New York.*)

Breast Cancer, by Albert Segaloff, M. D. (\$5.00, *C. V. Mosby Co., St. Louis 3, Mo.*)

Difficult Diagnosis: A Guide to the Interpretation of Obscure Illness, by H. J. Roberts, M. D. (\$19.00, *W. B. Saunders Co., Philadelphia 5, Pa.*)

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You and Your Public

Good Organization of Office and Business Procedures Gives Physician More Time for Actual Practice

THE physician of days gone by may have been a poor businessman with little effect on his practice, but modern requirements of medicine decree that efficiency be the rule, not the exception in office economics.

Today's physician must learn and apply good techniques of office management, personnel policies, maintenance of records, accounting and housekeeping. Each of these functions has a direct bearing on the physician's personal public relations.

The physician who operates an efficient, adequately staffed office is actually freeing himself from the business side of practice, and thereby providing more time for the professional side, as well as time for relaxation and recreation.

Avoids Criticism

This enables him to devote more time to his patients, and averts the often heard criticism: "The doctor didn't seem to have much time for me." While many aspects of medical practice have changed over the years, the human element remains the same. The patient still wants and should receive consideration as a person. When he receives such consideration, he looks with respect and appreciation upon his personal doctor and the profession.

Most of the public's criticism of medicine today is directed at the non-professional aspects, such as billing, appointments, records, etc. An AMA survey showed that patients complain more often about waiting to see their doctors than about the fees they are charged.

This would indicate that the busy doctor would do well to follow an appointment schedule, rather than hold "office hours." Most patients appreciate the consideration and convenience of appointments.

Appointments also make for more complete use of one's time. They conserve energy and eliminate much of the pressure that is encountered during "catch-all" office hours. They give the physician a reputation for thoughtfulness.

Provide Free Time

Appointments give the doctor time during the day to read his mail and journals, write up case notes, or for quick research on problems anticipated in patients to be seen on later appointments.

Here's a tip: On each list of appointments have written after the patient's name the complaint. This helps in reviewing the patient's medical history before he is seen.

Don't hesitate to keep a few appointment periods open. This helps to catch up when one gets behind schedule and provides for the unexpected patient or the emergency case.

Much has been written about the physician's office. In effect, his office is an extension of his own personality. Its layout, furnishing, staff and routines reflect directly on the physician.

The reception room should be one that "welcomes" the patient and makes him feel at ease. It should not be a "waiting room"—a drab, cold place that makes minutes of waiting seem like hours.

Privacy Required

The receptionist—be she receptionist, office nurse or girl Friday—should have a desk and phone that afford some privacy. Remember that the confidential nature of medical practice extends to the telephone. The person who receives and screens the physician's telephone messages can hardly do so freely if all persons in the waiting room can overhear her every word. This limits discussion with the patients, and thereby limits the amount of confidential information that can be obtained from the caller.

What about the office aide? If she is sympathetic but not maudlin, efficient but not overbearing, friendly but not chummy, courteous and interested, the physician has a valuable assistant.

Above all, she must have discretion.

The doctor who wants to make a solid contribution to the public relations of his profession need look no further than his office to demonstrate his consideration. He can show concern for not only his patient's comfort and welfare but for his pocketbook as well.

Patients, in most instances, are gratified and remember when a doctor treating a minor condition attempts to save his patient an extra office visit by suggesting the patient telephone him in a day or so rather than come in again.

In prescribing, many opportunities present themselves for showing the patient that you appreciate his money problems. If the drug is expensive, explain why. If possible, point out that the expen-

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sive drug can be expected to end the illness, thereby eliminating further expense.

Explanation Worthwhile

Do your patients tell their friends: "I like my doctor because he explains things"?

Explanation is most certainly in order when laboratory tests are ordered. The patient should be made to understand that they are necessary and pertinent to his case.

People visit the doctor in his office because they are in need of something. It may be because of a sprain or an upset stomach. It may be something far more serious.

They come to obtain medical treatment. Also, they come for reassurance and comfort against the unknown, pain or discomfort. The doctor who plans his office practice to provide time for personal consideration of his patients becomes a man of stature in their eyes.

AMA Rural Health Conference Scheduled March 5, 6, 7

The AMA's 14th National Conference on Rural Health will be held at the Broadview Hotel, Wichita, Kansas, March 5-7, with the conference theme being "Horizons in Rural Health."

Sponsored by the AMA Council on Rural Health, the conference will place special emphasis on such subjects as mental health, problems of the aging, nutrition, dental health, the costs of medical care and the various aspects of health insurance.

The meeting will be keynoted by Earl L. Butz, Ph. D., dean of agriculture and director of agricultural extension services at Purdue University, Lafayette, Ind. He will discuss "The Do It 'Yourself' Age." Dr. F. S. Crockett, Lafayette, chairman of the AMA council, will outline the horizons in rural health.

A special feature of the meeting will be a workshop Thursday afternoon dealing with community health participation. Citizens of a Kansas community will meet and discuss their community health problems and how they can obtain community participation in their solution. The workshop will be moderated by Dr. V. E. Wilson, assistant dean of the University of Kansas School of Medicine.

The Friday morning session will deal with medical care costs, hospital costs, and health insurance from the viewpoints of the physician, the hospital administrator, the insurance executive, the National Grange, the Farm Bureau, and the AMA.

LETTERS TO THE MEDICAL DIRECTOR

Dear Doctor:

Rauvera* was used on five patients with essential hypertension varying from moderate to severe. The highest blood pressure was 220/130 and the lowest 180/105.

All patients have shown a consistent response to the drug and the continuation therapy has effected a good control so far . . . approximately two to three months. In four patients systolic blood pressure was reduced from 20 to 50 mm. Hg and the diastolic from 10 to 15 mm. One patient, who had a pressure of 220/130 has had a phenomenal response, and I brought the systolic down to 165 and the diastolic to 95.

M. D., Wisconsin

Dear Doctor:

Rauvera has produced satisfactory reductions of blood pressure in every hypertensive case in which I have used it.

M. D., Colorado

Dear Doctor:

Rauvera tabs are my choice for hypertension over 170 . . . they give me the best results.

M. D., Texas

Comment: It is interesting to note that no adverse side effects were reported in connection with Rauvera's effective antihypertensive action.

*Rauvera contains 1 mg. alseroxylon (purified Rauwolfia serpentina alkaloid), 3 mg. alkavervir (Veratrum viride fraction) in each scored tablet.

SMITH-DORSEY • Lincoln, Nebraska



JUST 1 TABLET DAILY

WHENEVER SULFAS ARE INDICATED

KYNEX

Sulfamethoxypyridazine Lederle

provides therapeutic sulfa levels for 24 hours... Highly soluble... rapidly absorbed... produces fast, sustained plasma-tissue concentrations. Simple, easy-to-remember, single 0.5 Gm. daily dose. No crystalluria.¹

* with low incidence of sensitivity reactions... Extremely low in toxic potential.^{2,3} No cutaneous or other objective reactions seen in a wide scale study of clinical toxicity.² Even minor subjective reactions are not expected to occur² or are reported absent³ when recommended schedule is used.

TABLETS, 0.5 Gm., bottles of 24 and 100. New ACETYL PEDIATRIC SUSPENSION, cherry flavored, 250 mg. sulfamethoxypyridazine activity per teaspoonful (5 cc.), bottles of 4 and 16 fl. oz.

1. Editorial: *New England J. Med.* 258:48, 1958.

2. Vinnicombe, J.: *Antibiotic Med. & Clin. Ther.* 5:474, 1958.

3. Sheth, U. K., et al.: *Ibid.*, p. 604, 1958.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.
*Reg. U.S. Pat. Off.



Washington Roundup

News from the Nation's Capital of Interest to Physicians; Developments in Medical and Health Fields

Some 40,000 compounds are being tested annually for anti-cancer properties through Cancer Chemotherapy National Service Center, with 0.1 per cent reaching clinical trials, being conducted on 70 substances in 150 public and private hospitals.

* * *

Among Federal loans granted for college housing construction recently was \$500,000 to White Cross Hospital, Columbus, for student nurse dormitory construction.

* * *

Medical school consultants group which advises HEW Secretary Flemming is giving serious attention to the need for attracting more and better young people to medical careers rather than "space, rockets and engineering." Consultants also seek means of drawing talented researchers into medicine at the college level.

* * *

AFL-CIO Government Employees' Council (represents 500,000 Federal employees) is proposing health insurance for all Federal workers and their families, with U. S. paying two-thirds of basic costs (maximum \$14 a month) and employee paying other third, plus broader protection at his own expense. Council also proposes U. S. meet entire cost of catastrophic coverage, provided that employee has basic insurance. Employee would have choice of basic insurance, within limits.

* * *

Washington reports increasing Congressional interest in having U. S. promote more worldwide interest in medical research. Some proposals include an international medical year, international medical research foundation in cooperation with WHO, and more U. S. grants to foreign medical researchers.

* * *

National Science Foundation has a new science information service whose objective is to help coordinate growing volume of scientific information published in U. S. and abroad so this information can be available to American scientists.

* * *

Public Health Service interest in air pollution is evidenced in construction of two irradiation chambers at Robert A. Taft Sanitary Engineering

Center in Cincinnati to study action of sunlight on exhausts as basis for determining health effects of irradiated gases. The center also is experimenting on effect of auto exhausts on animals, plants and bacteria.

* * *

Surgeon General Burney of PHS has called for more emphasis on research aspects of financing health care of the aged. AMA Executive Vice-President Ernest B. Howard, M. D., said it would be "disastrous to jump into a full program so radical" as free hospital and surgical bills for the aged, while AHA President Ray Amberg voiced hope of solving "this problem without Federal aid." All three comments were made at HEW conference on "emerging health needs."

* * *

VA and American Cancer Society have launched a large-scale study on feasibility of sputum analysis as a mass screening test for lung cancer. About 8,500 residents of six VA domiciliaries are to be screened and given X-ray examinations twice annually. Dr. George N. Papanicolaou of Cornell will direct one of the cytology centers which will check cell samples. VA expects the study also will provide data on relationship of smoking, symptoms of bronchial and lung irritations, and infections to the development of lung cancer.

* * *

In another cancer research development, National Cancer Institute conducted the first cytoanalyzer field test in which the analyzer batted 1,000 by spotting all of 20 known positive or suspicious slides among more than a thousand negative slides. The device also earmarked 600 of the negative slides as "questionable" and the remainder as "definitely negative," thus reducing the cytologist's reading time.

* * *

American Association of Blood Banks has initiated a nation-wide master index to help identify rare blood types. The index is kept at the Milwaukee, Wis., center. Plans are to set up 12 regional reference laboratories for help in identifying a sample resistant to routine cross-typing.



in every
arthritic state...

maintenance therapy is still fundamental treatment

Sound, conservative therapy with salicylates has been consistently reaffirmed as basic, long-term maintenance therapy in the arthritides.^{1,2,3.}

Buffered Pabirin provides superior maintenance therapy. It epitomizes fundamental long-term basic therapy since it can be given month after month without serious complications and with minimal problems to patient and doctor alike.

Buffered Pabirin is formulated to provide high and sustained salicylate blood levels. Each tablet consists of an outer layer containing a buffer (aluminum hydroxide), para-aminobenzoic acid, and ascorbic acid; a core of acetylsalicylic acid.

In the stomach, the outer layer quickly releases the buffer, which protects against nausea, dyspepsia and other gastrointestinal symptoms so frequently encountered with salicylates alone. The core of Buffered Pabirin then disintegrates rapidly, permitting rapid absorption of the acetylsalicylic acid for faster pain relief.

References: 1. Hart, D.; Bagnall, A. W.; Bunim, J. J., and Polley, F. H.: Ninth International Congress on Rheumatic Diseases, Toronto, Ont. (June 25) 1957. 2. Report of Joint Committee, Medical Research Council & Nuffield Foundation, Treatment of Rheumatoid Arthritis, British Medical Journal (April 13) 1957. 3. Friend, D. G.: New England J. Med. 357:278 (Aug.) 1957.

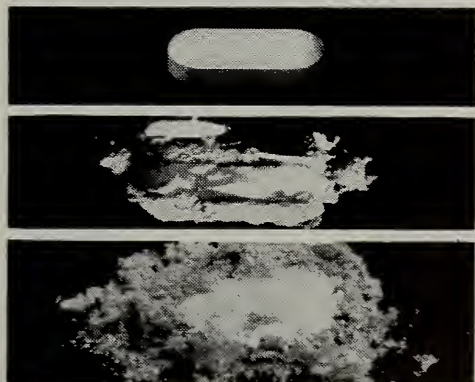
Buffered **Pabirin®** *Tablets*

Each tablet contains:

Acetylsalicylic acid (5 gr.).....	300 mg.
Para-aminobenzoic acid (5 gr.).....	300 mg.
Ascorbic acid.....	50 mg.
Dried aluminum hydroxide gel.....	100 mg.

All Buffered Pabirin is sodium- and potassium-free.

Dosage: Two or three tablets 3 or 4 times daily.



*Photographs show 2-stage
Tandem Release disintegration.*

In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

NOW IS THE TIME TO PROMOTE POLIO VACCINATION PROGRAMS

In our opinion every Ohio physician should take an active part in the current intensive drive to promote polio vaccinations. Now is the time for the protection of children and young adults against the hazards of the next polio season. These steps are recommended: County Medical societies should work out plans for providing shots for those who cannot afford to pay for them, providing such plans are not now in operation.

It is recommended that:

Each physician should assume responsibility for making sure that all members of families he sees are fully vaccinated.

State medical societies should work with State health departments to bring county and local medical societies together with health departments to work out vaccination programs.

County medical societies should meet with local health departments to make surveys of local problems and devise ways to meet local situations.

In 1958 there was more paralytic polio in the United States than in 1957, although less than in any other year in the last 15. Attack rates were highest in one-year-olds. More than 50 per cent of the paralytic cases were under five years. The vaccine continues to show a high rate of effectiveness (about 87 per cent), and duration of immunity is "holding up well." Evidence indicates it continues to be effective among persons vaccinated more than three years ago.

It is conceded that "face to face" campaigns will have to be conducted under sponsorship of local groups to reach the "hard-to-get" segment of the population, in many areas identified as low-income families. Campaigns will have to be on a block-by-block, home-by-home basis to be effective.

POLICY ON HEALTH FUND DRIVES IS CLARIFIED

The AMA House of Delegates acted wisely at the Minneapolis meeting in December when it clarified its position on the united fund drive question.

Obviously, it is up to local communities to make the final decision. Expressions of sentiment from the top are not out of line but dictation and compulsion are subject to question.

The AMA House of Delegates adopted a res-

olution expanding upon the one approved last June at San Francisco since that one "has been interpreted by some as disapproving the inclusion of voluntary health agencies in the United Fund drives. . . ."

The delegates declared: "The American Medical Association neither approves nor disapproves of the inclusion of voluntary health agencies in United Fund drives. . . ."

REQUEST FOR FUNDS TO PROVIDE HOSPITAL INSPECTION HAS MERIT

Dr. Ralph Dwork, Ohio Director of Health, has included in his budget request to Governor DiSalle an appropriation of some \$75,000 to enable the ODH Division of Hospital Facilities to license and inspect general hospitals. To date, no funds have been allocated for this work.

This is another case where legislative action fixed a state department with specific responsibilities but failed to provide funds for administration of the responsibilities. As a result, there have been little, if any, inspection and approval of Ohio's 201 general hospitals. Obviously, this is not good. It makes a joke out of a law enacted in good faith.

Allocation of adequate funds for this program is in the best interests of the general public. It is hoped the General Assembly will give serious consideration to this problem.

"THE THIRD PARTY — FRIEND OR FOE?"

Here are some thought-provoking observations made by Theodore Wiprud, executive director of the District of Columbia Medical Society, in discussing the subject, "The Third Party—Friend or Foe?"

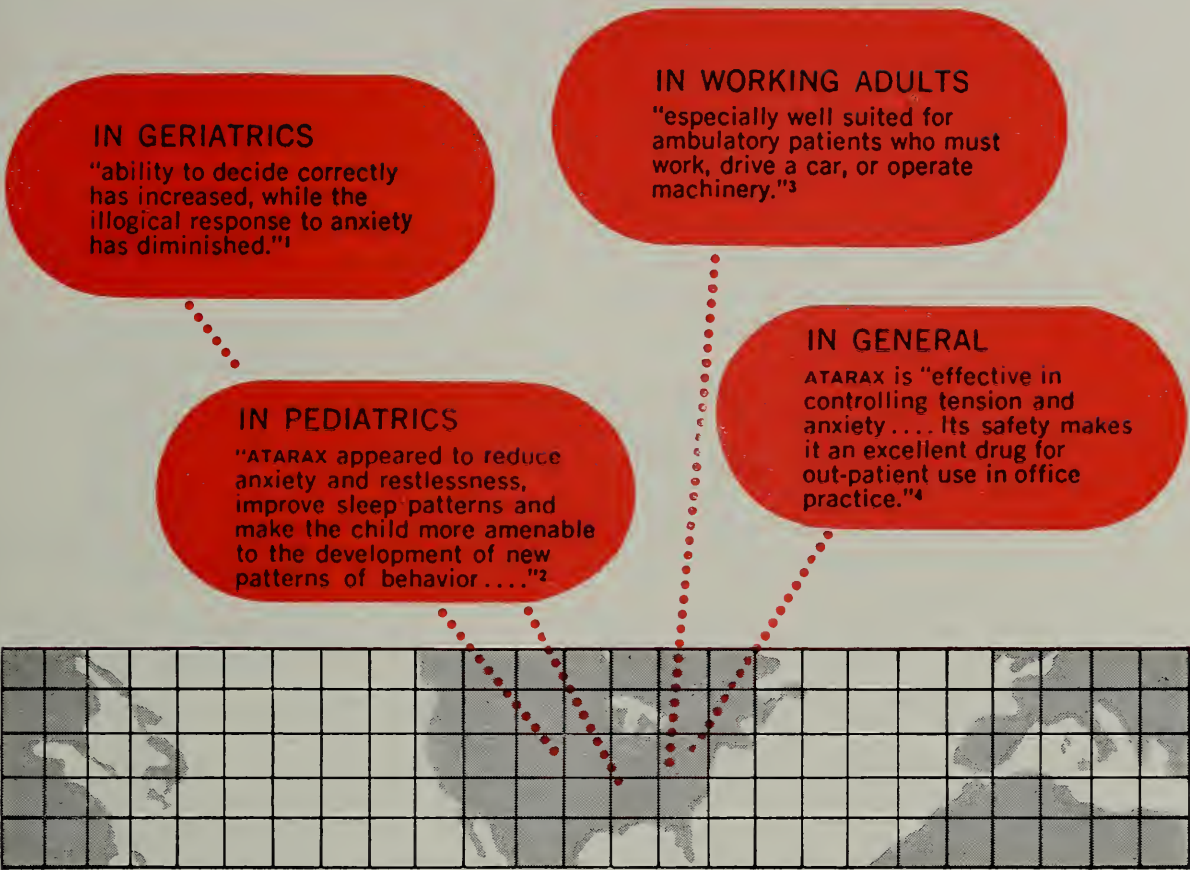
"Is the third party situation the menace it appears to be? What elements in the third party arrangement are essential to safeguard the best interests of patients and physicians? What should be done to win sympathetic public support for the medical profession's point of view? I have discussed these questions with a number of physicians engaged in private practice for whose judgment I have the highest regard. The following, with slight variations, is a consensus of their views.

"They were unanimous on one point—inroads of third party medicine will continue and will

re-evaluating tranquilizers?

READ WHAT CLINICIANS ARE
NOW SAYING ABOUT ATARAX®

(brand of hydroxyzine)



INVESTIGATORS AGREE ON OPTIMAL ATARAX DOSAGES

For childhood behavior disorders	10 mg. tablets Syrup	3-6 years, one tablet t.i.d. over 6 years, two tablets t.i.d. 3-6 years, one tsp. t.i.d. over 6 years, two tsp. t.i.d.
For adult tension and anxiety	25 mg. tablets Syrup	one tablet q.i.d. one tbsp. q.i.d.
For severe emotional disturbances	100 mg. tablets	one tablet t.i.d.
For adult psychiatric and emotional emergencies	Parenteral Solution	25-50 mg. (1-2 cc.) intramuscularly, 3-4 times daily, at 4-hour intervals. Dosage for children under 12 not established.

• **Supplied:** Tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

• **References:** 1. Smigel, J. O., et al.: J. Am. Ger. Soc., in press. 2. Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958. 3. Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957. 4. Menger, H. C.: New York J. Med. 58:1684 (May 15) 1958. 5. Coirault, M., et al.: Presse méd. 64:2239 (Dec. 26) 1956. 6. Bayart, J.: Presented at the International Congress of Pediatrics, Copenhagen, Denmark, July 22-27, 1956.

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Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being

expand. As one physician wrote me, 'I believe you will agree that there is nothing on the horizon lessening third party activities. I only hope that we will recognize that we have both friends and foes and will consider each case on its merits. To fight the inevitable on general principle is to fight a losing battle.'

"Of course, this physician said he did not mean that the profession had to accept anything that was handed it. He did mean that there would have to be some pretty objective thinking in the top echelons of organized medicine about the third party issue. First things, he insisted, will have to come first, and where medicine is concerned that is, as it always must be, the welfare of the patient.

"Whether the third party is friend or foe in the minds of most physicians depends upon three things: (1) acceptance of the free choice principle, (2) noninterference in professional matters, and (3) adequate compensation, preferably on a fee basis.

The best assurance of maintaining free choice, my medical associates insisted, is for the profession to see to it that the quality of medical service is kept at a uniformly high level. Most physicians with whom I talked believe that much more should be done to assure the people that they need have no concern on this score.

"Another barrier to acceptance of the free choice principle, according to physicians with whom I have discussed the subject, is failure of medical organizations to take effective disciplinary action against wayward members. Grievance committees, in most instances, they say, are soft, cautious, or ineffectual.

"The most prized prerogative of a physician is his freedom to exercise his professional judgment without interference. This is something that medicine has fought for with unyielding vigor. It is vitally important to patients as well as to physicians.

"Whether the third party is a friend or foe then depends a great deal upon medical leadership. This is especially true where the voluntary health insurance plans are concerned. The medical profession needs to know more about these plans and those who administer them. Without question, they are organized medicine's most valuable instrument in dealing with medical costs."

CERTIFICATES FOR DIABETIC PATIENTS

One section of the Ohio Narcotics Act—Sec. 3719.172—reads as follows:

"No person, except a manufacturer or wholesaler or retail dealer in surgical instruments, owner of a pharmacy, pharmacist, practitioner, nurse or

other person authorized to administer narcotic drugs, shall possess a hypodermic syringe or needle or any instrument or implement adopted for the use of habit-forming drugs by the subcutaneous injection for the purpose of administering habit-forming drugs, unless such possession is authorized by the certificate of a physician issued within the period of one year."

Physicians should realize that this could result in an embarrassing situation for a diabetic patient possessing a hypodermic syringe at the time of some sudden illness when law enforcement officers are called in for first-aid. Obviously, the section quoted is not intended to apply to cases of this kind.

Physicians should volunteer providing their diabetic patients—other patients, also, who may have a legitimate right to carry a syringe—with a proper certificate.

The Personal Health Information folder which is available from the American Medical Association carries a place where reference to diabetics and their need for insulin injections can be inserted.

These folders may be secured by physicians from the Ohio State Medical Association office or from the AMA. The folder is designed for carrying in the individual's billfold.

It may be that local diabetic societies have cards which patients can carry or might wish to consider making such cards available to physicians for use in proper cases.

The card or folder should carry information as to how the patient should be handled in an emergency and the warning that he should receive proper medical attention promptly.

Whatever is used, whether it be a card or a folder, the signature of the physician attesting to the facts set forth should appear. This will give added assurance of proper handling of the case by the police or others.

TRAGEDIES EMPHASIZE CARE NECESSARY IN PRESCRIBING

Chicago newspapers recently reported a tragic and preventable death. A physician's prescription for a specific number of "drams" of a sedative was interpreted in ounces instead, with the result that the patient received about 48 times the average prescribed dosage.

Ohio newspapers in October carried many words about the death of twin boys following an overdose of a drug resulting from a garbled prescription made via telephone.

No attempt is being made here to place the blame. As one editorial said "probably no system



new 3-way
build-up for
the under par
child...

Improve appetite and energy

with ample amounts of vitamins—B₁, B₆, B₁₂.

strengthen bodies with needed protein

Through the action of L-Lysine, cereal and other low-grade protein foods are up-graded to maximum growth potential.

discourage nutritional anemia

with iron in the well-tolerated form of ferric pyrophosphate...plus sorbitol for enhanced absorption of both iron and B₁₂.

new

NCREMIN*
Lysine-Vitamins
WITH IRON SYRUP

delicious
cherry flavor—
no unpleasant
aftertaste

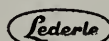
Average dosage is 1 teaspoonful daily. Available in bottles of 4 and 16 fl. oz.

Each teaspoonful (5 cc.) contains:

L-Lysine HCl	300 mg.
Vitamin B ₁₂ Crystalline	25 mcgm.
Thiamine HCl (B ₁)	10 mg.
Pyridoxine HCl (B ₆)	5 mg.
Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
Sorbitol	3.5 Gm.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

*Reg. U. S. Pat. Off.



can be devised that will absolutely remove the chance of human error in medical prescriptions."

Nevertheless, tragedies such as these should serve to emphasize to each physician how cautious he must be in prescribing—orally or in writing. Prescriptions when written should be legible. When prescriptions are telephoned, extreme care should be exerted by the physician to make the order understandable. It might be wise for the physician to do his own telephoning of prescriptions so the druggist can ask questions and check with him where there is the slightest doubt.

Here are some additional suggestions which, if followed, will save the physician and druggist grief.

The only narcotics which can legally be prescribed orally are those which contain codeine, dihydrocodeinone and a few other less common ones, and only when these narcotics are in some *combination* with another ingredient or ingredients. For example, you *can not* orally prescribe codeine sulfate $\frac{1}{4}$ grain tablets, but you *can* prescribe empirin compound with codeine $\frac{1}{4}$ grain. Just remember the eligible narcotics must be in combination with something else.

Also, a slight misunderstanding still exists as to the mailing of barbiturate prescriptions after given over the telephone. The Revised Code of Ohio, Sec. 3719.24, states "any practitioner who gives a barbiturate prescription to a pharmacist by telephone shall give a written prescription to such pharmacist within seventy-two hours after such telephone message."

You might request the pharmacist to mail you a copy of your telephoned prescription for your signature.

SEVEN PER CENT CAN CARRY A REAL WALLOP

Two thousand California physicians were asked the question: "When you are out of town, what arrangements are made for taking care of patients?" According to published results, seven per cent of those polled stated "leave patients on their own to get help."

We've no way of knowing what a similar poll in Ohio would show. We're inclined to believe that Ohio would be no better, no worse than California.

If that is true, then this observation made by the California Medical Association's Public Relations Committee warrants serious consideration by Ohio physicians as well as those in California:

"Seven per cent of California's voting patients could create a mighty stir—could generate a powerful political impact should they turn to government to get their medical help."

Cook County Graduate School of Medicine

INTENSIVE POSTGRADUATE COURSES

STARTING DATES—EARLY 1959

SURGERY—Surgical Technic, two weeks, Mar. 2, Mar. 16. Surgery of the Colon & Rectum, one week, Mar. 2, April 6. Basic Principles in General Surgery, two weeks, Apr. 13. Gallbladder Surgery, three days, Apr. 6. Surgery of Hernia, three days, Apr. 9. General Surgery, two weeks, Apr. 27. Board of Surgery Review Course, Part II, two weeks, May 11. Fractures & Traumatic Surgery, two weeks, Apr. 6. Treatment of Varicose Veins, two days, Mar. 2, Apr. 6.

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, Mar. 16. Vaginal Approach to Pelvic Surgery, one week, Mar. 9. General & Surgical Obstetrics, two weeks, Mar. 30.

MEDICINE—Electrocardiography, two-week basic course, Mar. 16. Gastroscopy & Gastroenterology, two weeks, Mar. 2. American Board Review Course (Part II), to be announced.

UROLOGY—Two-week intensive course, Apr. 27. Ten-day practical course in Cystoscopy, by appointment.

RADIOLOGY—Diagnostic X-Ray, two weeks, Mar. 2, Apr. 27. Clinical Uses of Radioisotopes, two weeks, May 4.

TEACHING FACULTY — ATTENDING STAFF OF COOK COUNTY HOSPITAL

Address: Registrar, 707 South Wood Street, CHICAGO 12, ILLINOIS

What Standex wouldn't do for her!



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FOR SAFE, EFFECTIVE WEIGHT CONTROL

THE LATEST "TIMED DISINTEGRATION" CAPSULE

- BALANCED APPETITE DEPRESSANT
- CENTRAL NERVOUS STIMULANT
- NUTRITIONAL SUPPLEMENT

Each Standex capsule contains:

D'Amphetamine Sulfate	7.5 mg.
Amobarbital	30.0 mg.
Vitamin B-1	1.0 mg.
Vitamin B-2	2.0 mg.
Vitamin B-6	0.1 mg.
Calcium Pantathenate	1.0 mg.
Niacinamide	20.0 mg.
Vitamin C	30.0 mg.

Reference literature and samples available from sales representative or write direct:

Standex LABORATORIES, INC.
Columbus, Ohio

83%
MAJOR
(Grade I and II)
IMPROVEMENT*

in Rheumatoid Arthritis

*Using combined drug therapy with **PLAQUENIL**® or Aralen® as maintenance therapy. With Plaquenil or Aralen alone 62% grade I and II improvement. (Scherbel, A.L.; Harrison, J.W., and Atdjian, Martin: Cleveland Clin. Quart. 25:95, April, 1958. Report on 805 patients with rheumatoid arthritis or related diseases.)

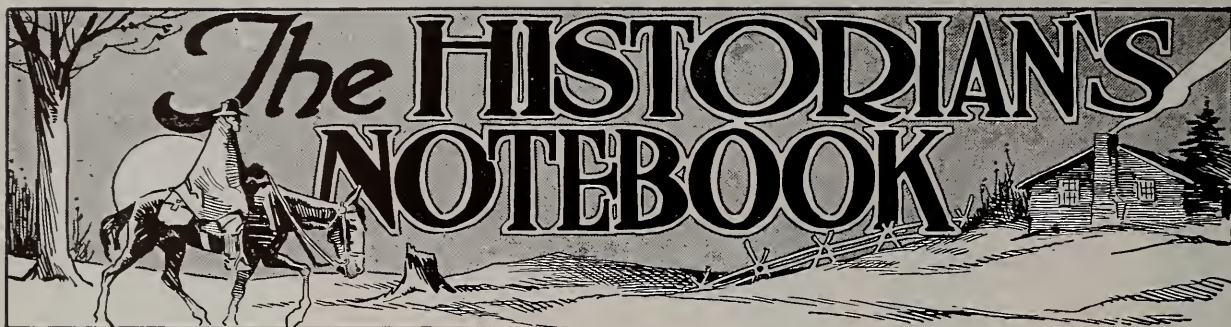
Reasons for Failure:

1. Treatment discontinued too soon (percentage of patients improved increases substantially after first six months).
2. Patients in relapse after prolonged steroid therapy are resistant to Plaquenil or Aralen treatment for several months.

Plaquenil sulfate is supplied in tablets of 200 mg., bottles of 100.

Dose: Initial — 400 to 600 mg.
(2 or 3 tablets) daily.
Maintenance — 200 to 400 mg.
(1 or 2 tablets) daily.

Write for Booklet.



U. S. Army Medical Service Contributions To Civilian Health and Medicine

FOR MORE than a century and three quarters the United States Army Medical Service has been searching for improved means for safeguarding the health of American soldiers. Many of the advances resulting from this work have benefited the civilian population of this and other countries.

As a matter of record, contributions from Army medicine go back to 10 years before the beginning of the Army Medical Service, since many of the Revolutionary Army medical officers had previously served in the Colonial wars.

In 1765 Dr. John Morgan, a Philadelphian who had served with the British in the Seven Years' War, helped to found what is now the University of Pennsylvania, America's first medical school. For this Morgan has been called the founder "of all medical education in the United States."

Dr. John Jones in 1775 wrote the first American textbook on surgery, *On the Treatment of Wounds and Fractures*. Jones was a surgeon with Colonial troops during the French and Indian War of 1758, and served as Surgeon's Mate in the American military service during the Revolution.

Hospital Planning

Jones and Dr. James Tilton, regimental surgeon and hospital physician in the Continental Army and later Army Surgeon General, cooperated in pioneering civilian hospital planning and construction in America.

The United States Army Medical Service began on July 27, 1775, when the Continental Congress set up "an Hospital"—by which they meant a medical department.

The first American pharmacopeia, published in 1778, was the work of William Brown, Physician

● This is the first of a series of articles about the contributions of the United States Army Medical Service to civilian health and medicine. Articles No. 2 and 3 will appear in the next two issues. The material was compiled by the Office of the Surgeon General, Technical Liaison Office, Washington, D. C., and released in July, 1957.

General of the Middle Department of the Continental Army. It was used extensively during the Revolutionary War by military and civilian pharmacists alike.

In 1800 Dr. Benjamin Waterhouse, a surgeon of the Regular Army, introduced smallpox vaccination into the United States. He crusaded for the cause, earning the title "Jenner of America." Vaccination has become nearly universal in this country and smallpox has been virtually eliminated.

In 1812 Dr. Benjamin Rush, probably the most famous physician of Revolutionary times, wrote the first American textbook on psychiatry. He was among the first to advocate the humane care and treatment of the mentally disturbed.

Every person cured of a digestive disorder today owes a debt to the studies of Army surgeon William Beaumont. In 1822 Beaumont, stationed in the back-country of Michigan, was brought a half-breed Indian who had been accidentally shot in the stomach. The patient lived but the wound never healed and, through the fistula into the stomach, Beaumont was able to observe over a period of years the processes of digestion. Beaumont's book, *Experiments and Observations on the Gastric Juice and the Physiology of Digestion*, published in 1833, was a foundation-stone of the

modern science of gastroenterology. Dr. William Osler called Beaumont "the pioneer physiologist of the United States, and the first to make a contribution of enduring value."

The Armed Forces Medical Library—a treasure trove of medical information used by students of medicine throughout the world—has been called "America's greatest gift to medicine." Surely this is the Army Medical Service's greatest gift to medicine.

Since Army Surgeon General Joseph Lovell established the collection in 1836 as the "Surgeon General's Library," the library has grown until, in the words of the Hoover Commission report, it is "the largest and most important medical library in the world."

Containing more than 650,000 bound volumes and growing at the rate of more than 25,000 per year, it has served civilian agencies and health workers since 1892.

Index to Literature

The Library's *Current List of Medical Literature* indexes more articles than any other medical index, is more up to date than any other, and is widely used by the civilian medical profession.

The Library's photoduplication service processes 100,000 requests a year. Its loan facilities handle more than 30,000 magazines and books a year. Its reference section answers about 1,000 questions per month. One third of this workload is for nongovernmental use.

This Library became the National Library of Medicine on October 1, 1956, after Congress by special legislation removed it to the jurisdiction of the Public Health Service.

The Army Medical Service kept the first reports upon which American vital statistics are calculated. Some of the first chiefs of the Medical Service required their officers to keep these records. For this and other reasons, many of the early annual Reports of The Surgeon General of the Army are prized reference works for genealogists, among others.

The first important publication on vital statistics, carefully compiled and analyzed, was prepared by Assistant Surgeon Samuel Forry under the direction of Surgeon General (1836-1861) Thomas Lawson. It embraced 20 years—January 1819 to January 1839—and appeared in 1840. Other such publications have appeared periodically, as gathering vital statistics is a continuing function of the Office of the Army Surgeon General.

Col. John Shaw Billings, the surgeon and bibliographer, one of the best statisticians of his

day, contributed medical and vital statistical data in connection with the censuses of 1880, 1890, and 1910. In 1880 he suggested that the various statistical data of the living and the decedent "might be recorded on a single card or slip of paper by punching small holes in it, and these cards might then be assorted and counted by mechanical means according to any selected group of these perforations." His suggestion was developed by Herman Hollerith of the Bureau of the Census into the first tabulating machines which used punched cards.

Surgeon General (1862-1864) William A. Hammond not only excelled as an administrator but also in the field of research. He pioneered in the therapeutic use of animal extracts, and in 1857 published *Experimental Research Relative to the Nutritive Value and Physiological Effects of Albumin, Starch, and Gum, When Singly and Exclusively Used as a Food*. Noted for his experimental research in physiology and physiological chemistry, Hammond's efforts served as a model for subsequent nutritional and metabolic research.

Institute of Pathology

Today's Armed Forces Institute of Pathology is an outgrowth of the Army Medical Museum established in 1862 by Surgeon General Hammond as a part of the reorganization of the Medical Department during the Civil War.

At the Institute young pathologists of the Army, Navy, Air Force, Veterans Administration, Public Health Service, and young men from universities and hospitals (American and foreign) have been trained. Visitors—interns, professors, research students—come to the Institute to study for one day or six months.

The Institute's registries of pathology have an important place in American medicine. A registry consists of pathologic material so organized that cases can be processed and used for research purposes. For 15 years a lending program has been in operation.

Today, sets of histologic slides based on registry files and covering most of the medical and surgical specialties are available without charge to any physician, civilian or military, in the United States. These loan sets are designed to meet the needs of pathologists and other clinical specialists.

Also, from the Institute's Photographic Department has come the Medical Illustration Service. This service collects, prepares, publishes, exhibits, and files illustrative material of medico-military importance which, whenever possible, is made available to other federal agencies, civilian institutions, and qualified physicians.

(To Be Continued in March Issue)

R

Tao

PRONOUNCED TAY-O

(triacetyloleandomycin)

Capsules / Oral Suspension

* designed for
superior control of
common Gram-positive
infections



in the
patient:

95% effective in published cases¹⁻⁸

Conditions treated	No. of Patients	Cured	Improved	Failure
ALL INFECTIONS	558	448	80	30
Respiratory infections	258	208	31	19
Pharyngitis and/or tonsillitis	65	58	5	2
Pneumonia	90	66	17	7
Infectious asthma	44	38	—	6
Otitis media	31	29	2	—
Other respiratory (bronchitis, bronchiolitis, bronchiectasis, pneumonitis, laryngotracheitis, strep throat)	28	17	7	4
Skin and soft tissue infections	230	191	38	1
Infected wounds, incisions and lacerations	41	33	8	—
Abscesses	51	43	8	—
Furunculosis	58	51	6	1
Acne, pustular	43	28	15	—
Pyoderma	19	19	—	—
Other skin and soft tissue (infected burns, cellulitis, impetigo, ulcers, others)	18	17	1	—
Genitourinary infections	28	19	3	6
Acute pyelitis and cystitis	10	8	2	—
Urethritis with gonorrhea or cystitis	8	8	—	—
Pyelonephritis	4	1	—	3
Salpingitis	5	1	1	3
Pelvic inflammation with endometriosis	1	1	—	—
Miscellaneous	42	30	8	4
(adenitis, enteritis, enterocolitis, subacute bacterial endocarditis, fever, hematoma, staphylococcus carriers, osteomyelitis, tenosynovitis, septic arthritis, acute bursitis, peri-arthritis)				

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PERRY R. AYRES, M. D., *Editor*

CHARLES S. NELSON,
Managing Editor — Bus. Mgr.

R. GORDON MOORE,
Asst. Managing Editor

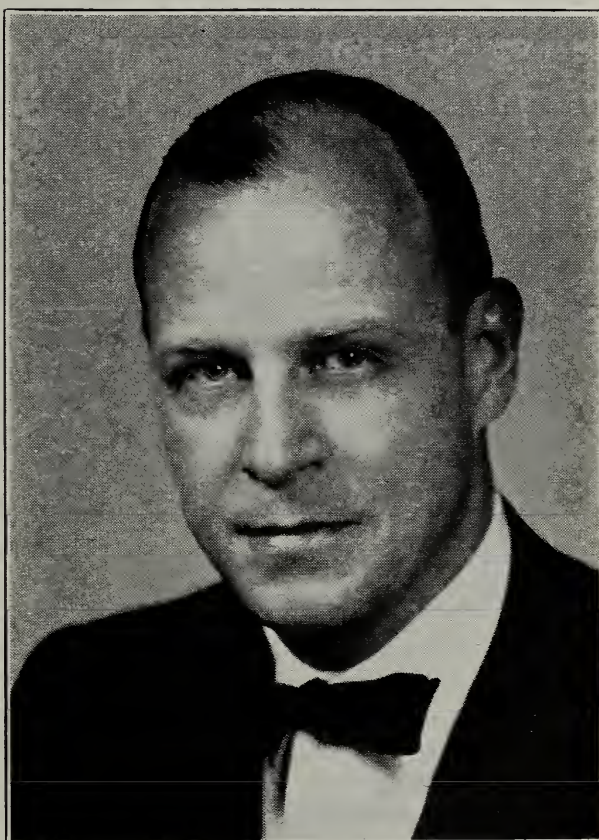
Dr. Perry R. Ayres Appointed Editor of The Journal

ON BEHALF of The Council, I have the privilege of presenting to the membership the new editor of *The Journal*—Perry R. Ayres, M. D., Columbus, succeeding Dr. Jonathan Forman, who resigned last October. During 1957 and 1958, Dr. Ayres was editor-in-chief of *The Bulletin of the Columbus Academy of Medicine*, having served as associate editor of the publication from 1951 to 1957.

Born in Columbus in 1917, Dr. Ayres attended the Columbus Public Schools, Oberlin College and Western Reserve University School of Medicine from which he received his doctor of medicine degree in 1942. Following internship at Syracuse University Medical Center in 1942-43, he was called to active duty with the USNR. For three years he served as battalion surgeon with the 10th Amphiban Tractor Battalion, 4th Marine Division in four campaigns—Marshall Islands, Saipan, Tinian and Iwo Jima, receiving a Presidential unit citation and Bronze Star medal.

At the close of World War II, Dr. Ayres entered residency training at Cleveland City Hospital, from 1946 to 1947 in pathology and 1947 to 1950 in internal medicine. In 1950 he opened a practice in internal medicine in Columbus, with special interest in cardiology. He is assistant clinical professor of medicine at Ohio State University College of Medicine; member of the active staffs at University and Mt. Carmel hospitals; member of the courtesy staffs of several other Columbus hospitals; and consultant for the Veterans Administration Hospital, Dayton, and Mt. St. Mary Hospital, Nelsonville.

Dr. Ayres is a diplomate of the American Board of Internal Medicine (1951); member of the American Society of Internal Medicine; and associate of the American College of Physicians. In 1956 he served as president of the Columbus Metropolitan Health Council and in 1958 he was



Perry R. Ayres, M. D.

vice-president and a trustee of the United Community Council. Since 1957, Dr. Ayres has been a member of the Board of Directors of the Ohio Citizens' Council for Health and Welfare and in 1958 he was elected to the Board of Directors of Ohio Medical Indemnity, Inc.

Dr. and Mrs. Ayres are the parents of three daughters. Mrs. Ayres is the former Helene Pur Dun who prior to their marriage in 1942 served as assistant registrar at the Western Reserve University School of Medicine.

—GEORGE A. WOODHOUSE, M. D.,
President.

The Diagnosis of Thyroid Disease in Private Practice

JACK MARKS, M. D., and RICHARD L. FULTON, M. D.

THE practical application of the radioactive isotopes of iodine to clinical medicine has been of great value in enhancing our understanding of the metabolism of iodine and the physiology of the thyroid gland. However, as more and more tests of thyroid function have been developed, clinicians are often confounded by conflicting and contradictory data from the laboratory. Occasionally, one or several of the thyroid function tests are found to be at variance with the physician's clinical appraisal of the patient.

This study was undertaken in an effort to ascertain to what extent the 24 hour I^{131} uptake determination has correlated with the clinical diagnoses of our patients. Determinations of basal metabolic rates and serum cholesterol, being available in many of our patients, were similarly analyzed. It has been shown in numerous reports that the determination of the protein-bound iodine content of the blood is a very helpful test in evaluating the thyroid status. It was not included in this study because it is our opinion that this test is very inaccurate and often misleading unless it is performed in a laboratory specifically designed for such analysis under rigidly controlled conditions.

We have reviewed the charts of 242 ambulatory patients who were studied at The Columbus Medical Center over a two year period for disorders of thyroid function.* Of this group, 12 patients were excluded from the study: three patients who had I^{131} determinations performed at less than 24 hours; four patients who were taking iodides or who were inadvertently tested at less than four months following x-ray studies employing iodinated contrast media; five patients who had an insufficient period of follow-up observation or in whom a definite thyroid diagnosis could not be made.

An inherent detractor of this study and those of a similar type is that clinical diagnoses were not established independently of and without reference to the laboratory data. This, of course, represents a theoretical flaw in the statistical premise of our

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- Dr. Marks, Columbus, is instructor of clinical medicine, Ohio State University; on staffs of University, Mount Carmel, St. Anthony, and White Cross Hospitals.
- Dr. Fulton, Columbus, is assistant professor of clinical medicine, Ohio State University; associate director, The Columbus Medical Center; on staffs of University, Mount Carmel, Grant, White Cross, and St. Anthony Hospitals.

study; however, it is one which we have sought to minimize in the re-evaluation of our cases.

Of the 230 patients in this study, 174 were diagnosed as euthyroid, 45 as hypothyroid and 11 as hyperthyroid. Of the latter group, seven patients had Graves' Disease and four had toxic nodules. Table 1 presents the data obtained in these cases.

Analysis of Data

The I^{131} uptakes of all patients of this series were divided into three categories of percentiles. Category I represents those individuals whose I^{131} uptakes were below the 25th percentile (corresponding to an I^{131} uptake of 21 per cent). Category III represents those individuals whose I^{131} uptakes were above the 75th percentile (corresponding to an I^{131} uptake of 36 per cent).

Category II represents those patients whose I^{131} uptakes were between the 25th and 75th percentiles. The cut-off points were selected on a statistical basis without regard for previously published normal ranges. (Table 2) The crucial cells of this table are Cell 1 in Row 1*, Cell 2 in Row 2*, and Cell 3 in Row 3*. As can be observed, these are the cells with the highest frequencies for the clinically hypothyroid, euthyroid, and hyperthyroid patients, respectively. The resulting chi-square is 57.55 at 4 degrees of freedom. The probability that these results might have occurred by chance are much less than one in one thousand. There is, therefore, excellent correspondence between the clinical diagnosis and the I^{131} uptake.

Of the 174 patients who were classified as euthyroid clinically, 56 per cent fell into the II Category with uptakes of 21 to 36 per cent. Had the category been expanded to include the 20th percentile to the 80th percentile (corresponding

* Our instrument for the study of the I^{131} uptakes is a decade scaler (Nuclear Chicago), Model D-181 with a Scintillation Detector, Model SC-2M, which embodies a 1 by 1 inch thallium activated sodium iodide crystal, with a window thickness of 20 mgm/cm² and a sensitivity range of 0.05 to 50 mr/hr.

Our source of Iodine¹³¹ is commercially calibrated capsules (Abbott Radiocaps). In 173 consecutive determinations, our tracer doses ranged from 2.8 uc to 29.0 uc with a mean value of 7.3 uc. The larger tracer doses were employed in those patients who had differential scanning of the thyroid gland.

TABLE 1

	No. Cases	Range I ¹³¹	Mean I ¹³¹	No. BMR's	Range BMR	Mean BMR
Euthyroid	174	8.5 — 69.8%	29.9%	103	—30 to +20%	— 4.4%
Hypothyroid	45	0 — 46.8%	18.4%	36	—40 to +20%	—11.5%
Hyperthyroid	11		57.6%	9	— 8 to +52%	+18.0%
Toxic Nod.	4	20.0 — 90.6%	29.9%			
Graves' Dis.	7	44.4 — 86.0%	64.0%			

	No. Cases Cholesterol	Range Cholesterol	Mean Cholesterol
Euthyroid	116	128 — 360 mgm./100 ml.	195.9 mgm./100 ml.
Hypothyroid	37	135 — 360 mgm./100 ml.	200.5 mgm./100 ml.
Hyperthyroid	7	125 — 210 mgm./100 ml.	168.0 mgm./100 ml.

TABLE 2.—Frequency Distribution of Three Categories of I¹³¹ Uptake and Clinically Hypothyroid, Euthyroid and Hyperthyroid Categories

	I ¹³¹	Hypo	Euthy	Hyper	Total
(I)	< P ₂₅ (21%)	30* (66.7%)	35 (20.1%)	1 (9.1%)	67
(II)	P ₂₅ — P ₇₅ (21% to 36%)	9 (20.0%)	97* (55.7%)	1 (9.1%)	107
(III)	P ₇₅ (36%)	6 (13.3%)	42 (24.2%)	9* (81.8%)	56
Total		45 (100%)	174 (100%)	11 (100%)	230

Chi-square = 57.55 at 4 d.f.

P < .001

TABLE 3.—Frequency Distribution of Hypothyroidism, Euthyroidism, and Hyperthyroidism as Related to BMR.

Thyroid Category	B < —10	M —10 to +10	R > +10	Total
(I) Hypo	22 (61.1%)	13 (36.1%)	1 (2.8%)	36 (100%)
(II) Euthy	32 (31.1%)	62 (60.2%)	9 (8.7%)	103 (100%)
(III) Hyper	1 (12.5%)	3 (37.5%)	4 (50.0%)	8 (100%)
Total	55	78	14	147

 $\chi^2 = 26.689$ at 4 d.f.

P < .001

to I¹³¹ uptakes of from 19 per cent to 38 per cent), then 71 per cent of the clinically euthyroid patients would have been included in this range. Above the 25th percentile (I¹³¹ uptake of 21 per cent) were 33.3 per cent of the clinically hypothyroid patients. Below the 75th percentile (I¹³¹ uptake of 36 per cent) were 18.1 per cent of the hyperthyroid patients.

Table 3 presents a frequency distribution of the clinically hypothyroid, euthyroid, and hyperthyroid patients with regard to the basal metabolic rate determinations of (I) below minus 10 per cent, (II) from minus 10 per cent to plus 10 per cent and, (III) above plus 10 per cent. The chi-square is 26.689 at 4 degrees of freedom and the probability that this distribution might have occurred by chance alone is far less than one in one thousand. This indicates good correlation between

the clinical diagnoses and the basal metabolic rate determinations.

Sixty-one and one-tenth per cent of the hypothyroid patients had basal metabolic rates of less than minus 10 per cent, 36.1 per cent of the hypothyroid patients had basal metabolic rates of from minus 10 per cent to plus 10 per cent, and 2.8 per cent of the hypothyroid patients had basal metabolic rates above plus 10 per cent.

Thirty-one and one-tenth per cent of the euthyroid patients had basal metabolic rates of less than 10 per cent, 60.2 per cent of the euthyroid patients had basal metabolic rates of between minus 10 per cent and plus 10 per cent, and 8.7 per cent of the euthyroid patients had basal metabolic rates of more than plus 10 per cent.

Of the hyperthyroid patients, in a very small series, 12.5 per cent of patients had basal metabolic

TABLE 4.—Frequency Distribution of Hypothyroidism, Euthyroidism, and Hyperthyroidism as Related to Cholesterol Determinations

Cholesterol	THYROID CATEGORY			Total
	Hypo	Euthy	Hyper	
(I) P ₂₅ (<160)	5 (13.9%)	22 (18.6%)	2 (33.3%)	29
(II) P ₂₅ — P ₇₅ (160 — 225)	22 (61.1%)	67 (56.8%)	4 (66.7%)	93
(III) P ₇₅ (>225)	9 (25.0%)	29 (24.6%)	0 (0%)	38
Total	36 (100%)	118 (100%)	6 (100%)	160

$\chi^2 = 2.789$ at 4 d.f.
P = n.s.

rates of less than minus 10 per cent, 37.5 per cent had basal metabolic rates of from minus 10 per cent to plus 10 per cent, and 50.0 per cent had basal metabolic rates of more than plus 10 per cent.

Table 4 presents the frequency distribution of the three thyroid categories in relation to serum cholesterol determinations.** The cholesterol determinations were divided into these categories according to percentiles. The cut-off points were (I) below the 25th percentile (corresponding to a serum cholesterol of 160 mgm. per 100 ml.), (III) above the 75th percentile (corresponding to a serum cholesterol of 225 mgm. per 100 ml.), and (II) corresponding to serum cholesterol determinations between the 25th and the 75th percentiles. The cut-off points were selected on a statistical basis without regard for any theoretical physiologic normal range. The chi-square is 2.789 and is not significant; therefore, the obtained correspondence between the hypothyroid, euthyroid, and hyperthyroid patients did not exceed chance expectancy.

Discussion

The clinical value of the measurement of radioactive iodide accumulation in the thyroid gland is predicated on the correlation between the thyroid gland's avidity for iodide and the peripheral thyroid hormone's effect. The usual clinical experience indicates that such correlation is proximate; however, the clinician should not lose sight of the dichotomy of these two phases of thyroid metabolism. As Nadler and LeBlond³ have recently noted, the trapping phase of thyroid metabolism may be inhibited by substances that do not appreciably affect other aspects of thyroid function, and the iodide concentrating mechanism is separable from the organic binding of iodide to protein. VanderLaan³ has noted the capacity of sulfanilimide and thiocyanate to inhibit the thyroid gland's capacity to take up iodide.

Propylthiouracil and Tapazole® (methimazole), among the commonly used therapeutic blocking

agents, interfere with the conversion of iodide to iodine so that iodination of tyrosine does not occur. The iodide trapping mechanism is relatively intact in such treated individuals. Astwood³, who has done so many important studies in this area, believes that the mechanism of this block is an enzymatic inhibition which interferes with the thyroid's peroxidase system.

The 24 hour I¹³¹ uptake determination represents one of several tests that have been employed to measure the thyroid gland's capacity to concentrate iodide. Other such tests differ from this 24 hour test principally in time. One hour, 2 hour, and 6 hour tests have been employed. McConahey et al. have given data to suggest that the 6 hour test is more discriminating diagnostically than the 24 hour test; however, the 24 hour method is far more convenient in terms of clinical practicability.

The steepness of the curve of iodide accumulation, the so-called accumulation gradient, has also been employed. Dobyns⁴ has pointed out that this test does not indicate the rate of accumulation alone but rather represents a summation of the uptake and release curves. Both Bauer and Teplets⁴ have noted the tendency for euthyroid patients, previously treated for hyperthyroidism, to develop recurrent toxicity when the gradient of uptake is steep even though the 24 hour uptake be quite normal.

Clinical Variables Altering RAI Uptake

A wide variety of clinical states are being described in which there is poor correlation between the concentration phase of thyroid metabolism (as measured by the I¹³³ uptake test) and the peripheral thyroid effect. Pitt-Rivers et al.,⁵ in demonstrating that the peripheral cell is capable of deiodinating thyroxine to triiodothyronine, have introduced the possibility of a failure of such deiodination resulting in a deficient metabolic state. In such cases, the thyroid gland itself may be functioning physiologically.

Barker³ has commented upon the work of Recant

** Sachett's Method

and Riggs relating to the hypometabolic state existent in nephrosis and thought to be attributable to a loss of protein-bound iodide through the kidneys. Roche and co-workers have investigated the metabolism of iodine in the iodine-poor Venezuelan Andes and have noted a high degree of efficiency of the thyroid gland in people living in this region. While the I^{131} uptakes were normal or slightly elevated, they noted marked thyroid avidity for iodide, with reduction of renal iodide excretion, elevated conversion ratios and low salivary iodide excretion. These studies demonstrate the iodine-saving adaptation of these subjects to chronic iodine deprivation.

Goitrogenic blocking agents have been found to be present in the diet of persons living in certain regions of the Carpathian Mountains¹ and recently Clements and Wishart have investigated the presence of a potent thyroid blocking substance in the milk consumed by Tasmanian school children.

Clinical and laboratory studies of patients with defective thyroid intermediary metabolism are accumulating. Stanbury³ has described two goitrous hypothyroid siblings whose thyroid glands produced unphysiologic circulating diiodotyrosine and monoiodotyrosine which were being excreted in significant amounts in the urine. These individuals were shown to lack the capacity to deiodinate these substances and suffered a state of chronic iodine deficiency.

Stanbury⁴ has recently summarized four distinct thyroid metabolic disorders of goitrous, hypothyroid individuals. Briefly, these are (1) a type that releases iodide after the administration of thiocyanate; (2) a type with monoiodotyrosine and diiodotyrosine in the blood, mentioned above; (3) a type with a very high I^{131} uptake and thyroxine in the blood but with a very slow release phase; (4) a type described by McGirr⁴ with huge goitre, high I^{131} uptake and retention without rapid release in whom no more than 55 per cent of the I^{131} was butanol-extractable. It seems probable that other such defects will be discovered.

Additional causes of disparity between the clinical thyroid status of patients and the I^{131} uptake test have recently been cited by Cassidy and VanderLaan.⁶ They have noted elevated uptakes in the presence of congestive heart failure, with simple goitre, in renal disease, and in liver failure. They cite two instances of elevation of the I^{131} uptake in the presence of hypochloremia, the mechanism of which is unknown. Low I^{131} uptakes were noted in some forms of liver disease, after ACTH and corticosteroid therapy and in the presence of anterior pituitary failure. These investigators advocate the Thyroid-Suppression

Test as a means of distinguishing the true thyrotoxic individual from the euthyroid patient with elevated I^{131} uptake. The test basically is one of performing an uptake study after 21 days of the administration of 180 mgm. of Thyroid, U.S.P. daily. If this dose of exogenous thyroid suppresses the uptake, the patient is felt to be euthyroid. If, on the other hand, the I^{131} uptake remains above the normal range, then the patient is felt to be actually thyrotoxic. This test may prove a valuable adjunct to clinical thyroid diagnosis.

Kohn and Nichols have shown that a popular vitamin-mineral capsule containing 0.5 mgm. of iodide per capsule was effective in lowering the uptake of radioactive iodide and in inducing an appreciable rebound or heightened I^{131} uptake after the capsules had been discontinued.

The toxic nodule may have a predilection for iodine uptake, rendering the remainder of the gland relatively hypoactive. In such instances, the I^{131} uptake may be normal or low, but the conversion ratio and the protein-bound iodine tend to be high.

Precautions

The following factors are very important in interpreting the results of the radioactive iodine uptake test:

- (1) The ingestion of thyroid and iodides tends to suppress the I^{131} uptake. Ideally one should wait one month after the patient has discontinued thyroid medication before performing the test. The length of time in which iodides may interfere with the test is dependent upon the form of such medication and the dosage.

- (2) If the test is performed while a patient is taking such blocking agents as propylthiouracil and Tapazole, only the Iodine- 131 will be measured which has been "trapped" in the gland for a brief period. These agents prevent the incorporation of the I^{131} molecule into the protein moiety of the colloid.

- (3) Radiographic procedures which employ iodinated contrast media, such as intravenous pyelography, cholecystography, myelography and bronchography may so flood the circulation with stable Iodine- 127 that the uptake of Iodine- 131 may be low for years due to the saturation of the circulation with the stable iodine molecules. Although barium employed in upper and lower gastrointestinal roentgenograms contains small amounts of iodine, the low concentration and absorption does not seem to conflict with radioactive iodine studies.

Conclusions

- (1) Our data indicate that the 24 hour radioactive iodine uptake determination has a high de-

gree of correspondence with clinical thyroid diagnoses and should be employed whenever possible in helping to establish the status of the thyroid gland.

(2) The basal metabolic rate determination has been used for many years in the evaluation of thyroid gland function. Our studies further established this test as a very worthwhile procedure in the study of the thyroid gland.

(3) The serum cholesterol determinations performed in our series were inconstant and of very questionable value in evaluating thyroid gland function.

(4) While the I^{131} uptake and the basal metabolic rate determinations are helpful tests, they impose a challenge on the clinician in many borderline patients with hypo- and hyperthyroidism. The practicing physician is obliged to hold to his clinical impression at times when the imposing documentation of the scintillation counter or the oxygen consumption curve is at variance with his judgment. Our studies lead us to believe that neither the 24 hour I^{131} uptake test nor the basal metabolic rate are clearly diagnostic in many borderline cases and that even after an entire "battery" of tests have been performed, the clinician must still come to a conclusion on clinical grounds.

Low Beer,⁴ we believe, has stated the problem accurately: "Radioactive uptake studies are very valuable. However, in clinically clear-cut cases of hyper- or hypothyroidism, we really do not need this study. We need a method for that small group of borderline cases in which we always have the problem of reaching a decision, whether we are dealing with a true hyper- or hypothyroid state. . . . In the final conclusion about a case, we most often rely greatly on our clinical judgment."

Acknowledgment: We wish to express our thanks to Dr. Salomon Rettig, Research Division, Columbus Psychiatric Institute and Hospital, Columbus, Ohio, who gave us valuable assistance in the statistical analyses of our cases.

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Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEFFEL, M. D.
Columbus, Ohio, Chairman

Following is the summary of a case which was discussed before the Franklin County Pelvic Cancer Delay Committee on November 19, 1958, at its regular monthly meeting held at the University Health Center.

Case No. 65

Patient is a 62 year old white female first seen in 1955 because of pruritis vulvae. She had had discomfort for a period of 36 months. Local biopsy reported as leukoplakia of the vulva with premalignant changes. Simple vulvectomy was carried out. Final diagnosis was leukoplakia with premalignant changes.

Patient returned to physician three years later with presence of a nodule in line of excision. Diagnosis from biopsy revealed squamous cell carcinoma of the vulva.

Comments

DR. EZELL: From time of original diagnosis to a period of three years later patient had no follow-up. In spite of good prophylactic care in form of simple vulvectomy this patient had progression of her disease from a premalignant state to a malignant state.

DR. POMEROY: These patients have poor response to massive radiation. Treatment of choice is radical vulvectomy.

DR. HOLZAEFFEL: This case represents a three year time loss in follow-up on the part of the physician. Given a diagnosis of a premalignant lesion, the patient should be seen at least every six months. The role of false modesty in the elderly individual prone to carcinoma of the vulva is gradually being overcome by educational means. These individuals are seeking aid earlier than in the past generation. It is the physician's responsibility to maintain a close surveillance on any patient that has a diagnosis such as leukoplakia.

Hypercortisonism in Patients With Rheumatoid Arthritis

Patients with rheumatoid arthritis treated with excess doses of adrenal steroids may develop a syndrome in addition to the usual manifestations of Cushing's syndrome. This is characterized by a triad of cyclic mood changes, fatigability, and musculo-skeletal aching. Furthermore, these patients seem susceptible to so-called "mesenchymal reactions" which may simulate lupus erythematosus, a flare of rheumatoid arthritis, or periarteritis nodosa. Treatment of these special features of hypercortisonism consists in the steady, gradual reduction of dosage in small decrements according to the patient's reaction to the withdrawal.—James W. Kemper, M. D., Houston: *Texas State J. Med.* 54:839, December, 1958.

Rx. — *Light Duty*: What Is It?

KEITH C. KEELER, M. D.

ON occasion following an illness, an injury and/or an operation, an employee is returned to his place of employment bearing a note from the family physician which reads, "May return to light duty," or "Permitted to do light work." As one contemplates a definition of "light duty" or "light work," it becomes readily apparent that the term has a broad spectrum from no work to heavy work, may be limited by time, and by production rate.

Is the interpretation of the term "light work" by the family physician, industrial physician, employer, and by the patient identical? Obviously not, because of varying backgrounds. The question does not seem to revolve about whether to re-employ the patient, but rather the type and amount of work permissible.

By way of example, an employee was returned to work at a large industrial plant following an acute exacerbation of a previous back complaint; light work was suggested. He was placed on an elevator. Some weeks later the patient returned for another series of physical therapy treatments to his back. A description from the patient of his actual job duties indicated that the particular freight elevator in question had a gate on either end. To admit a passenger, he had to stoop to lift the gate; and to close, he had to reach overhead to pull it down. On those occasions when the gate became stuck, the additional stress or sudden jerk aggravated the worker's symptoms. Thus, job placement following an illness or injury requires interpretation of the employee's physical limitations and existing capacities in terms of job requirements.

Clearly, a definition of "light work" can apply to only one individual having a given physical potential at a given time. In order to stimulate thinking, I shall discuss in generalities re-employment following fracture of an extremity bone, a coronary heart condition, and an operation for repair of a hernia, in order to illustrate factors to be considered in applying clinical data to job requirements.

Re-employment Following an Operation For Hernia

Studies on the healing of abdominal wall surgical incisions show three histological phases: (1)

Read before the Section on Industrial Medicine at the Annual Meeting of the Ohio State Medical Association, April 15-17, 1958, Cincinnati.

The Author

● Dr. Keeler, Akron, is Medical Director, Rehabilitation Center of Summit County, Inc.

Inflammatory; (2) Destructive; and (3) Proliferative. During the first two phases, referred to as the lag period in wound healing, catabolic products are removed from the wound site; fibrinogen and globulin in the tissue fluid form fibrin which provides the framework of the bridge across the incision. No wound tensile strength is present during these early phases, which last five to seven days.⁵ This lag period is essentially the same for skin, fascia, and muscle.²

The proliferative phase of fibroplasia now begins. As fibroblasts begin to branch, precollagen, which takes the silver stain and sometimes is designated immature collagen, is laid down. By the tenth or eleventh postsurgical day, a change to mature collagen is distinguished by its failure to take silver stain. This histological change parallels clinical evidence of increasing wound tensile strength.^{3,5} In the healthy child the rate of increase of wound tensile strength is comparable to that of the healthy adult.¹

General factors, such as disturbed electrolyte balance, dehydration, circulatory impairment, acidosis and alkalosis, affect wound healing. Also, local conditions such as infection, hematoma, chemical irritants, inadequate apposition, or strangulation suturing govern the rate of development of wound tensile strength. Nutritionally, Vitamin C hastens the formation of collagen.⁵

Thus, in the presence of favorable general and local physiological conditions, mature collagen develops by the fourteenth postoperative day, giving maximal tensile strength to the surgical incision. In terms of the abdominal wall wound, then, re-employment at the end of two weeks is theoretically feasible. An instrument to measure wound tensile strength clinically would provide the surgeon with objective evidence of wound healing, and in turn, employability. The ability to lift a 50 pound truck tire after a herniorrhaphy is dependent primarily on wound tensile strength. However, independent of wound tensile strength, trunk and extremity muscle weakness alone may prohibit early return to employment. Full mention

cannot be made of vascular and renal dysfunctions, nor other general metabolic changes accompanying postsurgical convalescence.

Determination of employability following an operation for an uncomplicated hernia should be as objective as feasible. In the absence of more objective tools, this might best be accomplished by a series of tests in the form of simulated work activities which would place numerical values, in terms of weight, total time, work rate, that an employee could push, pull, carry, lift, upon reporting for duty following surgical repair of a hernia. Such a trial of lifting or pushing specific weights in a medical department under supervision also develops a feeling of self-confidence in the patient recuperating from an operation.

Such simulated work testing has even more implications in those persons who present themselves for re-employment following intra-abdominal surgical processes. Surgical procedures upon intra-abdominal organs and viscus present additional concomitant alterations of metabolic functions.

Therefore, to determine the ability of an employee to return to his regular work, or to establish the degree of "light work" he may safely do, it is suggested that simulated work testing might obviate medical ambiguity relative to re-employment following even simple surgical procedures such as repair of a hernia.

Re-employment Following Fracture

The orthopedic, or traumatic surgeon uses a standard time interval, x-ray films, and clinical examination to determine tensile strength, or healing of bone.

Functional use of an extremity, after healing of a fracture is as important as anatomical alignment of bone at the fracture site. For locomotion, and indeed for most unskilled or even skilled employment, function is determined by range of motion of joints on either side of the fracture, plus muscle strength. Muscle strength should be sufficient to support body weight plus enough reserve strength to absorb additional stresses placed upon the body at a given instant.

For example, it has been calculated that a 150 pound man who jumps from a 10 foot platform must dissipate approximately 3700 pounds of stress through his lower extremities if the impact lasts 0.1 second. As you know, this is possible without fracturing a bone by bending the ankles, hips and knees, permitting rapid dissipation of stress through elastic as well as inelastic tissue. This particular illustration tends to emphasize my point that in our daily life situations arise in recreation and employment which demand unexpected, momentary stress on muscles, ligaments, and bones.

Appraisal of the patient's functional capacity for employment must be interpreted in relation to the usual and emergency requirements of his individual job. It is suggested that an attempt be made mathematically to determine job demands in terms of muscle power, which is Weight times Distance per unit time.

Given a man of x number of pounds body weight, carrying an additional load of y number of pounds up z number of steps, we can estimate fairly accurately how many pounds of DeLorme weight and how many repetitions the quadriceps muscle must lift the weight to meet this objective. Physical therapy is continued at least to that point. This then gives meaning and objectivity to rehabilitation therapy after an injury, such as a fracture.

Usable motion is that amount which the patient can actively flex, extend or rotate a specific joint. Active motion does not always correspond to passive motion because of muscle weakness, muscle contractures, or fibrous tissue shortening. Nonetheless, if 30 degrees of active motion at a particular joint is all that is required in a particular job, then, theoretically, 30 degrees motion makes him employable. Range of functional joint motion is attained through muscle strength; and conversely, the ability of muscle to acquire strength is largely dependent upon active joint range of motion.

Again, by way of illustration, following a fracture of the humerus, a truck tire builder requires full shoulder motion plus perhaps 100 pounds of deltoid muscle strength; whereas, a bookkeeper could probably work satisfactorily with only 75 per cent shoulder motion and five pounds of deltoid muscle strength.

To reiterate, assuming a fracture has healed, joint motion and muscle function should be equated to job demands in order to find the level of light work or full labor which the patient employee can perform.

Re-employment Following Cardio-Respiratory Lesions

Determination of physical capacity following cardio-respiratory disturbances involves the appraisal of stress on the entire body. Pertinent to re-employment, it is desirable to know (1) the extent of the pathological involvement of the heart and/or the lungs; and (2) the body's response to stress in the presence of these lesions.

By stress again, we mean energy expenditure, or in the engineering vernacular, power output. Recalling your high school physics, work is defined as Mass times Distance. Power is work per unit of time. Therefore, the amount of stress a patient convalescing from coronary thrombosis can

tolerate without producing progression of the pathological process or clinical signs and symptoms should be equated against his job demands. Since this is an equation, similar nomenclature must be used on both sides of the equation, such as foot-pounds of work per hour.

Symptoms of cardiac stress such as fibrillation, wave changes on the electrocardiograph, oxygen debt may not become evident until a particular level of activity, or stress, is reached. This stress level at which cardiac symptoms develop might be considered the point of maximum physiological power output.

Defining that level of work tolerated by the patient-worker has been vague, because until only recently have attempts been made to ascertain demands of the job upon the worker.

Passmore and Durnin⁶ have collected the largest amount of data on physiological response to job stress. I have taken the liberty of summarizing this material into arbitrary categories as outlined in Table 1, labeled Light Work, Moderate Work, Moderately Heavy Work and Heavy Work.

TABLE 1.—Energy Expenditure in Performing Specific Tasks

LIGHT WORK (Energy expenditure less than 3.0 calories per minute)	
Employment	Calories per minute
Music—woodwind, flute, accordion, violin, cello, trumpet, piano, conducting	2.0 - 2.7
Painting - easel	1.2 - 1.5
Factory Work	1.6 - 3.0
Lathe turning	
Light assembly	
Drafting	
Watch repairing	
Radio mechanics	
Printing, bookbinding	
Shoe repair, manufacture	
Tailoring	
Locksmithing	
Inspecting	
Mechanized forging (steel)	
Sawing - power saw	
MODERATE WORK (Energy expenditure from 3.0-5.9 Calories per minute)	
Sheet metal worker, joiner machinist, punching battery plates, punch press, metal turning, tool setting, stamping, gauging	3.0 - 4.5
Presser in dry cleaning	4.0 -
Construction—wheelbarrow, light shoveling, hammering, joining, plastering, stone mason, brick-laying	4.0 - 5.9
Steel—furnace man, smith, striker, wire drawer, molder	4.0 - 5.1
Driving—tank, large trucks	2.4 -
Farming—threshing, binding, weeding, hoeing, plowing by horse, milking by hand or machine, tractor operation	3.5 - 5.9
MODERATELY HEAVY WORK (Energy expenditure 6.0-10.0 Calories per minute)	
Construction—pick and shovel, wheelbarrow, hand sawing, chiseling, planing	7.0 - 10.0
Carry 10 pounds at moderate pace up stairs	
Coal mining—hewing, loading, drilling, pushing, packing	7.1 - 8.0
Iron & steel—hand rolling, forging, mill rolling, tending, sawpits, tipping molds	6.0 - 9.4
Farming—mowing, threshing, binding (hand)	7.0 - 7.7
Lumbering—trimming trees, cross-cut sawing, chopping, felling	8.4 - 10.0
Marching with full field pack	8.9 -

HEAVY WORK (Energy expenditure 10.0-15.0 Calories per minute)

Climbing ladder with moderate to rapid speed and with additional load	
Climbing stairs carrying 10-25 lbs. with moderate speed	
Postman climbing stairs with pack and at usual speed	10.0 - 14.0
Chopping with axe (30 blows per minute)	11.9 - 13.2

The response to work outlined in table 1 illustrates a measure of power output required by the body in performing certain specific tasks. It takes the same power output for a severe cardiac patient to do the same tasks as the noncardiac, healthy subject; but his ability to produce the necessary power is impaired because his capacity to maintain and recover from increased stress is lowered.

The Master's Two-step Test gives a simple clue to a patient's cardiac capacity. According to Hellerstein⁴ this test consumes 8.5 calories per minute. Thus, the Master's Two-step Test falls into the Moderately-Heavy Work category outlined above. Furthermore, it would appear that the American Heart Association's Functional Class 1 cardiac patient could perform those tasks in the foregoing Light Work and Moderate Work categories; Functional Class 3 patients could perform only those tasks listed under Light Work.

In summary, if Management asked an Industrial Physician whether a certain employee with known cardiac disease might lift a 35 pound tire, the physician may be able to give a better answer in the future when he knows not only how much, but also how far and how often the weight must be lifted in accordance with definitions of work and power. By equating clinical data to a job in the plant, the physician would be able to state the level of work the employee might do, following a coronary thrombosis. If his capacity should be below that required on his usual job in terms of foot-pounds per hour or similar terms, then the level of "light work" can be ascertained with reasonable accuracy.

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Tempered Optimism in Rehabilitation of The Severely Disabled Patient

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A MAJOR factor in the outcome of rehabilitation of the chronically ill or severely disabled patient is the attitude of the physician and his team of associates. It is basic to all medical management that the patient brightens with improvement or optimism, and becomes depressed with failure or pessimism. Optimism, transmitted to the patient is therefore a useful tool in the management of severely disabled patients. This optimism must be firmly tempered by reality. Tempered optimism is based on objective evaluation of the patient's disability and on the likelihood of his overcoming it, partially or completely.

Both physician and patient tend to err in the direction of pessimism on many occasions. The first step in the prevention of this error is the firm knowledge by the physician of the patient's physical capabilities. Against this background of physical potential, the physician can make an estimate of the patient's potential goals. He is then in a position to supply firm and relatively optimistic support for the patient during his rehabilitation program.

I have set down here some examples in which the general medical population tends to be overly pessimistic, and in which some increased optimism is warranted.

The hemiplegic: Many myths surround the treatment of the hemiplegic patient. The future of the hemiplegic is certainly brighter than the general medical impression would indicate. For instance, aphasia is considered a severe deterrent to self-care and ambulation training by many. At least in the case of motor aphasia, it presents no deterrent. The patient will still make a satisfactory ambulatory and self-care adjustment in the absence of expression. Receptive aphasia is something else again, and rehabilitation will be limited by the depth of verbal auditory agnosia, or by diffuse brain damage causing an inability to learn or understand.

The degree of brain damage consistent with ambulation training is remarkable. Almost all hemiplegics who survive the initial ictus in a con-

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scious state can be taught to walk, although continued supervision may be necessary for the more severely involved. Continued incontinence of bowel or bladder in the hemiplegic should be a very rare phenomenon. Most hemiplegic patients who appear at our chronic disease hospital with catheters soon have them removed. The catheter often represents a physician's or nurse's frustration at the patient's inability to use a signal bell. Regular presentation of a bedpan to the patient, or a routine trip to the bathroom may be all the training the patient needs.

Accidents in Therapy Unlikely

Also apropos of hemiplegics, many physicians demur from early and optimistic approaches to the patient because of a fear of coronary, hypertensive or cerebrovascular incidents occurring during therapy. In several hundred thousand treatment sessions involving a majority of severely disabled patients I have seen only one fatal pulmonary embolism, one very minor coronary occlusion unproven by electrocardiogram, and no cerebral vascular accidents occurring during therapy. This includes the whole gamut of therapies from ambulation to weight-lifting, and the full range of post-stroke durations, from several days to several years.

Emotional lability is a common finding in the early days after a cerebral vascular accident. Such lability is very often short-lived, and one can be relatively optimistic in predicting to the patient's family that the difficulty will largely resolve. This lability represents more often a reactive depression than a true pseudobulbar effect; it usually responds rapidly when the patient can be shown that he is improving in his ability to care for himself. True pseudobulbar emotionality can be best detected by its inappropriateness and its failure to respond,

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and can be expected in the presence of bilateral neurologic changes.

In hemiplegia, one is often tempted to assay prognosis by amount of paralysis present. This is an extremely unreliable method of determining whether or not a patient will be independent in walking or in self-care. A patient with complete flaccid paralysis of both limbs of one side stands an excellent chance of full rehabilitation. He needs a brace for his leg and some training for the other arm. Another patient, with partial control of arm and leg, with severe underlying spasticity or ataxia might be severely disabled, with a spastic arm getting in the way during dressing activities, and a spastic leg tripping him during the swing phase of gait.

Thus, in the hemiplegic patient, none of the following is sufficient to engender pessimism: aphasia, incontinence, paralysis, or emotional lability. Their appearance in combination need not be disastrous, for each problem is treated individually.

Age: The difference between physiologic and chronologic age has been dwelt on at great length in the literature and on podia in recent years;

I mention it here for the sake of completeness. Age itself is no indication for pessimism in rehabilitation.

The Amputee: Amputation presents another common source of discouragement to many practitioners. The below knee amputee can almost always be rehabilitated to complete ambulation activities, without a cane. The above knee patient sometimes needs a cane, but is a good candidate for complete ambulation. The problems enter particularly when bilateral amputation is considered. Arthur Watkins has recently reported a large series of bilateral amputees with 70 per cent successful rehabilitation to the ambulatory level. This gives us just cause to urge the unilateral amputee toward full ambulation. We know that even if he loses the second limb he will still stand a large chance of being rehabilitatable.

Optimism Must Be Tempered

Optimism of course can be carried too far. A realistic appraisal of the physical potential of the patient often turns up some unpleasant facts which must restrain any rehabilitation program. As an example of this type of restraint, the accompanying chart¹ shows the predicted physical potential of

Table II. FUNCTIONAL SIGNIFICANCE OF SPINAL CORD LESION LEVEL

ACTIVITIES		C-5	C-6	C-7	T-1	T-6	T-12	L-4
Selfcare:	eating	—	±	+	+	+	+	+
	dressing	—	—	±	+	+	+	+
	toileting	—	—	±	+	+	+	+
Bed Independence:	rolling over; sitting up	—	±	+	+	+	+	+
	moving about in bed: supine and sitting	—	—	±	+	+	+	+
Wheelchair Independence: transfer from (to) wheelch.)		—	±	±	+	+	+	+
Ambulation: functional (includes to standing position)		—	—	—	—	±	+	+
Attendant:	lifting	+	+	±	—	—	—	—
	assisting	+	+	+	±	±	—	—
Homebound Work With Hands		—	—	+	+	+	+	+
Outside Job		—	—	—	±	±	+	+
Private Car		—	—	—	±	+	+	+
Public Transportation		—	—	—	—	—	±	+
Braces or Devices		Hand	Hand	Hand LLPS	LLPS	LLP ± S	LL ± P	Sh.

Hand - hand devices (splints, slings, etc.) Braces: LL: double long brace; P: pelvic band S: spinal attachment; Sh: short leg brace.

CHART 1. Functional Significance of Spinal Cord Lesion Level. This indicates the predictable functional capacity of the paraplegic or quadriplegic patient with a complete spinal cord lesion, in the theoretical absence of complications.

spinal cord injury patients with paraplegia or quadriplegia at several critical levels.

Through objective evaluation of the patient's physical capacities, the physician can balance his own hopes and fears for the patient, or his own optimism and pessimism, and arrive at a plan which is firmly realistic. The problem then remains the transmission of this reality-based plan to the patient with minimal psychic trauma and the allowance of maximum hope, or optimism. This communication of information takes the form of the setting of goals for and with the patient.

There is an interplay between physician and patient concerning the acceptance of goals. The physician must have constantly in his mind several goals, not with the idea of fooling the patient, but with the idea of giving the patient the maximal continuous support consistent with his disability and therefore with reality.

He must have in mind a grossly realistic final goal to which the patient can aspire, and which he will attain if all goes reasonably well; call this a *probable final goal*. The probable, final goal is often a great source of hope to the patient if it is indeed an optimistic goal; for instance, the hemiplegic is often boosted immediately by the simple statement, "We can certainly teach you to walk!"

Limited Goals Useful

However, it is obviously not helpful to approach the patient early in his rehabilitation with a grossly depressing goal, no matter how realistic it may be. The C-6 quadriplegic is not going to be helped in the first month after his accident by being told that he will forever be confined to a wheelchair and require assistance in all but the simplest activities of daily life. Here, then, is an indication for a different type of goal for the patient—a *limited goal*.

The limited goal is a useful mechanism, not only as a method of diverting the patient's attention from the final goal, but also as a logical step toward reaching or accepting the real goal. A limited goal must be one which is almost inevitably attainable by the patient. For the severe quadriplegic patient it might be suggested that he concentrate on self-feeding activities for the present, that when he has become proficient at that level, we will discuss the next step. This may seem to be "cutting the dog's tail off inch by inch," but it is actually allowing the patient time to assimilate the severe trauma which has befallen him; it also gives him a chance to perform at a level where he is truly capable. Eventually, through the presentation of successive limited goals, the patient will come to realize his true capabilities and limitations. In some cases an actual presentation of the "final,

probable goal" is unnecessary, since the patient works this out as he goes through his program.

Still another type of goal can be called the *extraordinary goal*. In this case the physician finds himself in the situation of thinking the patient might, under short odds, do extraordinarily well. The chances are so small that he does not dare tell the patient of his high hopes, for fear of causing the patient frustration in the very large chance that the hopes will fail to materialize. This extraordinary goal the physician keeps in reserve, as a new path to be followed by him and his patient should things go well, or as an exhortation to greater effort to be used if the patient's ambition flags. It seems a nice bit of reasoning to determine whether an extraordinary goal is more likely to be useful or retarding if communicated to a patient.

Since goal-setting is important in producing a realistically optimistic feeling in the patient, the goals which are set for a patient must pervade every activity which he performs. Not only must physician and patient be thinking in the same directions, but so must every member of the team of professional and technical personnel treating him. The patient should be exposed only to a positively directed atmosphere. He should have the feeling that everyone treating him knows his case well, and agrees on what to do about it. He should be shielded from the behind-the-scenes disagreements of re-evaluation conferences and combined rounds.

Summary

Such disabilities as stroke and amputation are amenable to rehabilitation to a larger degree than is understood by many physicians. Although great strides have taken place in the education of physicians in this respect, there is still room for more optimism than is generally seen in many disabilities. This optimism must be firmly tempered by reality; the communication of this tempered optimism to the patient in the form of intelligent goal-setting will do much to further his rehabilitation.

1. Chart 1: Functional Significance of Spinal Cord Lesion Level, Long and Lawton: Archives of Physical Medicine and Rehabilitation; Vol. 36, No. 4, April, 1955.

Thyroid Cancer in Youth

Study was made of 11 patients under 20 years of age with thyroid cancer. Nine were girls and two boys. Eight of the patients had first sought medical advice because of cervical adenopathy. Nine of the patients had had x-ray therapy to the head and neck previous to the diagnosis of the thyroid cancer.—Donald W. Petit, M. D., Boris Catz, M. D., and Paul Starr, M. D., Los Angeles: *California Med.*, 89:394. December, 1958.

What's New in the Treatment of Schizophrenia?

JAMES L. SAGEBIEL, M. D.

THIS is indeed a timely topic since major advances in the treatment of this disease are now in the making. In 1956 for the first time in approximately 200 years in the history of the public mental hospitals of the United States, instead of the expected increase of 10,000 to 15,000 patients there was a reduction of over 7,000. This occurred at a time when the tranquilizing drugs came into widespread use. It is only a first step, however, toward meeting the problem of 750,000 hospitalized psychiatric patients, 60 per cent of whom are schizophrenic but it is highly significant that such a beginning has been made.

It is too soon to predict that the corner has been turned and that, like tuberculosis and poliomyelitis, mental illness is on the decline for we have not yet clearly delineated the causes nor have we reached the point where a specific drug can confidently be used for a particular psychiatric disorder or symptom.¹ The empirical trial and error method with different drugs and combinations will continue to be made for some time. Certain indications of their probable range of value have begun to show up and some order now seems to be evolving out of the initial chaos. The new psychotropic drugs have been classified² into the tranquilizers (phenothiazines, reserpine and glycidamide), the central relaxants (meprobamate), the ataractics (azacyclonol) and the antiphobics (benactyzine).

Phenothiazines Prove Beneficial

The phenothiazines appear to produce the best effects³ in cases of chronic schizophrenia. Appraisals of the effectiveness of treatment with chlorpromazine cover many thousands of cases. The percentage of remissions or marked improvement varies all the way from 52 to 93 per cent. This variability in results is no doubt an expression of the variables encountered in the patient groups such as duration of illness, type of schizophrenia, quantitative dose of the drug, duration of treatment, and the hospital atmosphere with such imponderables as personnel interest, unconscious if not deliberate psychotherapy, and occupational and social therapy.

The beneficial effect on reduction of hyperactivity, noisiness, assaultiveness and necessary re-

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straint has been a great boon to the mental hospitals and their personnel. Quiet wards now replace noisy disturbed wards; psychotherapy is now more readily administered. The other groups of drugs either have not fulfilled their earlier expectations or are still in an experimental stage and have not as yet proved themselves. The tranquilizers as a whole represent a new approach to the control of mental illness in that they have their effect on the higher neural centers in the general area of the diencephalon, selectively inhibiting the chemoreceptor trigger zone, the hypothalamus and the reticular substance. Direct stimulation of the reticular activating system produces a normal waking pattern and in agitated patients the tranquilizers specifically reduce this activity.

Side Effects and Dangers

It is quite obvious that so many new drugs are being developed that it is impossible to comment on all of them. It should be recorded, however, that while most of them have a beneficial effect on the intensity of the psychotic symptoms, they are not curative and many produce side effects, some of which may be dangerous. Reports on the toxic effects of chlorpromazine give variable percentages of the occurrence of clinical jaundice, leukopenia and a Parkinsonian-like syndrome.

The ataractics, exemplified by azacyclonol, while most effective in postoperative confusional and senile dissociation states, still have shown a beneficial effect in acute and chronic schizophrenias.³ In the acute form it is reported that two-thirds show good results and in the latter about 50 per cent. Azacyclonol has been found to be more effective when combined with electroshock therapy and some phenothiazine.

An antiphobic such as benactyzine has been only moderately helpful and has many objectionable atropine-like side effects.⁴ This drug has been discontinued by several workers.

Regressive Electroshock Therapy

Cases of chronic schizophrenia which have proved refractory to insulin coma, moderate electroshock

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therapy and the phenothiazines have recently come under closer scrutiny by investigators interested in a form of intensive electroshock therapy which regresses the patient to the point of complete behavioral disorganization.

This form of regressive electroshock therapy, while it has been used by only a few investigators over the past 10 or 12 years, has recently been more thoroughly studied as to its beneficial effects in refractory cases of chronic schizophrenia. Glueck and his co-workers⁵ consider it surprising that it has not been used as a standard form of treatment in refractory cases. They showed that the term "drastic" was not justified since the results were generally satisfactory, that it did not lead to permanent cerebral damage and that there were no greater side effects or complications than with less intensive electroshock therapy. Their technic was to give three grand mal convulsions each day until complete regression occurred. This was manifested by memory loss, confusion and disorientation, lack of verbal spontaneity, slurring of speech to the point of complete dysarthria or muteness, apathy, helplessness and loss of sphincter control.

A similar technic was employed by Cameron⁶ in his treatment of chronic paranoid schizophrenic patients who had failed to react to the usual therapies. Cameron's technic was that of a prolonged chemical sleep accompanied by extensive use of electroshock, four to five convulsions at two to three minute intervals being given daily until complete "de-patterning" of the patient was produced. This "de-patterning" is identical with Glueck's regression. Their rehabilitation technics are similar. This form of regressive electroshock therapy for refractory cases of schizophrenia has been receiving increasing attention during the past year.

Grantham Lobotomy

There has also been a wider acceptance of lobotomy procedures specifically aimed at reducing the affective overload without blunting of the personality. Grantham's technic⁷ consists of electrocoagulation of the ventromedial quadrant of both frontal lobes. This destroys the thalamocortical fiber tract chiefly concerned with affect transmission, leaving intact the cortical ganglion cell layers. The technic was most effective in those cases which showed intense anxiety or hostility uncontrolled by the other physical therapies. Striking results have been reported in many patients.⁸ Fulton⁹ stated that the Grantham technic is the greatest advance in lobotomy procedures to date.

Ayd¹⁰ considered it a tremendous advance in the field of psychosurgery.

Serotonin in Cortical Metabolism

Recently new concepts have been introduced in the investigative field by the work of Woolley, Heath, Altschule and others. Woolley¹¹ stated that schizophrenia probably results from a disturbance of the metabolism of tryptophan through 5-hydroxy-tryptophan to serotonin and that inadequate carboxylation results in an inadequate amount of serotonin in the circulating blood and therefore in the cortical ganglion cells. Using a benzyl analogue of serotonin (BAS) he found that if he protected the periphery from an excess, which would produce diarrhea and vasomotor collapse, by injections of dextro-amphetamine intravenously, he could give a sufficient amount to get through the blood-brain barrier and permit invasion of the cortical ganglion cells. When this method was used in chronic schizophrenics it caused amelioration of their symptoms. When the injection of serotonin was stopped, however, the patients returned to their former clinical states.

Taraxein

Further evidence that biochemical disturbances are related to malfunction of the brain and, therefore, the production of psychotic symptoms, includes the work of Heath¹² who isolated an extract of the blood of undifferentiated schizophrenics called taraxein and injected it into normal volunteers with the production of schizophrenic symptoms. Recently Heath, et al.,¹³ injected beef septal extracts into schizophrenic patients which produced a resolution of their symptoms. Chemically, these patients consistently showed an increase in the level of reduced glutathione such as Altschule¹⁴ reported for his patients receiving pineal extract. The speed of adrenalin oxidation was slowed and the serum copper levels dropped.

Ceruloplasmin

Serum copper, in the form of ceruloplasmin, an oxidizing enzyme, appears to be assuming a more important role. Martens,¹⁸ going on the assumption that an increase in ceruloplasmin is a compensatory mechanism against stress and that in schizophrenics this mechanism has become faulty, gave schizophrenic patients 1.0 g. of nearly pure ceruloplasmin daily intravenously for 13 days. He reported complete remissions in nine and improvement in 10 of 22 untreated schizophrenics.

Pineal Extract

Altschule¹⁴ reported that protein-free alkaline pineal extracts reversed the biochemical abnormalities of schizophrenics and caused clinical im-

provement. The nature of the active material is not known but is being investigated. The clinical improvement observed in these experiments differed from that noted when tranquilizing drugs were given. Although the latter produced changes in behavior they did not alter the basic chemical metabolic disorder.

Acetylcholine

Epinephrine has long been familiar to every physician and it may seem surprising that its metabolism and detoxification especially in the central nervous system is still quite obscure. It has been stated by Hoffer, Osmond, et al.,¹⁵ that adrenochrome and adrenolutin, both oxidized derivatives of epinephrine, have been observed to produce in human volunteer subjects psychological changes that fall within the range of schizophrenic reactions. They went on the assumption that the basic disturbance in persons with schizophrenia is an overproduction of acetylcholine and an abnormal diversion of epinephrine into some toxic indole which may be an acetylcholine esterase inhibitor. Administration of nicotinic acid removed the methyl groups which might be responsible for the toxic manifestations. They showed that injection of acetylcholine into the ventricles of animals or human subjects produced psychotic-like changes that could be reversed by the further administration of acetylcholine esterase.

Acetylcholine Esterase And Its Inhibitors

Furthermore, repeated administration of acetylcholine esterase produced marked improvement in the psychotic status of chronic catatonic schizophrenic patients.¹⁶ Administration of esterase inhibitors intraventricularly, such as bulbo-capnine, LSD-25, adrenochrome and adrenolutin, produced psychotic-like behavior. Thus, they found that decreasing the concentration of acetylcholine was of therapeutic value in schizophrenia. Clinically, reduction of the concentration of acetylcholine was accomplished by excessive doses of nicotinic acid and nicotinamide which materially contributed to the recovery of their schizophrenic patients.

On the other hand, Pfeiffer and his co-workers¹⁷ found that by administering 2-dimethylanimoethanol (DMAE) 250 mg. per day to schizophrenic patients they could materially increase motor and verbal activity and bring them into better reality contact. The therapeutic effects were slow, however, requiring as long as six months to become manifest.

They postulated that DMAE therapy will be made more effective in chronic schizophrenia

when biochemical adjuvants are found which will increase acetylcholine synthesis in the brain.

Thus, confusing and sometimes conflicting, reports have been coming out of current biochemical research on brain metabolism. Eventually these various problems will be resolved.

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Open Ward Management of Acute Alcoholism

Sixty acutely alcoholic patients were treated in unsegregated rooms of two to twelve beds in a general hospital to determine the feasibility of open ward care. Personnel caring for them were first educated in the nature of alcoholism, the aberrations it produces and treatment with tranquilizing drugs. Fears and objections were overcome.

Violent or unpredictable patients were excluded from the test, but those with alcoholic hallucinations or delirium susceptible to control were admitted. Preliminary physical examination was done to find out whether there was coincidental disease. In three patients, one with subarachnoid hemorrhage, one with severe anemia and one with pneumonia and shock, this examination followed by prompt treatment was probably life-saving. Tranquilizers, fluids and vitamins were given routinely, by mouth as soon as possible.

Alcoholic patients were found to be no more unmanageable than others.

If it were generally accepted that acutely alcoholic patients, diagnosed as such, could be admitted to open ward care in general hospitals, candor in diagnosis would be encouraged thereby, coincident disease probably would be promptly recognized if present, and long-term treatment for the alcoholic addiction could be begun early.—Jack David Gordon, M. D., Robert I. Levy, M. D., and Charles B. Perrow, M. A., *San Francisco: California Med.*, 89:397, December, 1958.

Physiologic Ovarian Cysts*

WARREN H. PEARSE, M. D.

THIS study was undertaken to aid diagnosis. Acute lower abdominal pain in the female poses at least two diagnostic problems requiring surgical management—appendicitis and ectopic pregnancy. Symptoms and complications arising from physiologic ovarian cysts may give a similar picture and yet best be managed conservatively.

Symptoms arising from rupture of the graafian follicle varying from the mildest "Mittelschmerz" to hemoperitoneum and shock are recognized and considered in all the standard texts, but little consideration is given to a definite clinical syndrome of rupture of the cystic corpus luteum. Taniguchi and Kilkenny published an excellent review of 19 cases in 1951 concerning hemorrhage from ruptured corpora lutea and a recent Canadian summary¹ studied all bleeding from the ovary. However, low abdominal pain not precisely at midcycle still frequently leads to surgery for appendicitis when watchful expectancy might avoid operation.

Several recent cases seemed to fall in the category of ruptured corpus luteum and we undertook to review the available hospital records over the past five years. In order to analyze the diagnostic problems in a logical sequence, we felt all of the "physiologic ovarian cysts" or the "benign non-neoplastic ovarian cysts" should be studied, with the exclusion of endometriosis. Seventy-one cases bore a diagnosis of follicle cyst, corpus luteum cyst or hemorrhage due to rupture of either. Their distribution is shown in table 1. Although we were primarily concerned with the ruptured cysts, all groups were considered.

Follicle Cysts

Thirty-four cases were diagnosed as follicle cysts. Of these four represented Stein-Leventhal type ovaries and eight were purely pathology findings usually with surgery for leiomyoma uteri or endometriosis. Six cases represented true follicle cysts which were over 5 cm. in diameter and palpable prior to surgery. Three of these were asymptomatic and three were associated with menorrhagia of two to six months' duration. The 16 ruptured follicle cysts will be considered later in more detail.

Corpus Luteum Cysts

Thirty-seven cases were diagnosed as corpus

The Author

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luteum cysts. Novak has pointed out that it is important to distinguish between a cystic corpus luteum and a corpus luteum cyst. The former is a cystic distention of a normal corpus luteum which may disappear with the succeeding menses, manifest itself through rupture premenstrually or for reasons unknown persists into the following cycle. The true corpus luteum cyst develops from a corpus luteum hematoma, always persists beyond the originating menstrual cycle, is usually palpable, usually does not give rise to bleeding abnormalities and often requires removal as a persistently palpable ovarian tumor of over 5 cm. in diameter.

Of the 37 cases of corpus luteum cysts, 14 were incidental findings at the time of pelvic surgery and were under 5 cm. in diameter. Ten apparently ruptured premenstrually and will be considered later in more detail. Six were present with bleeding abnormalities, usually spotting, of less than one month's duration. The combination of a unilateral pelvic mass and irregular spotting in these cases always raises the question of ectopic pregnancy and most of these were investigated by examination under anesthesia, cul-de-sac puncture and colpotomy or laparotomy with that diagnosis in mind. These 30 cases would be classified as cystic corpora lutea.

Seven were palpable ovarian tumors over 5 cm. in diameter, without menstrual abnormalities, discovered either on routine examination or as a re-

TABLE 1.—Distribution of 71 Cases
Of Ovarian Cysts Studied

	Cases
Graafian Follicle	
Incidental Findings	12
Ruptured Follicle Cysts	16
True Follicle Cysts	6
Total	34
Corpus Luteum	
Cystic Corpus Luteum	
Incidental Findings	14
Ruptured Premenstrually	10
Corpus Luteum Persists	6
Total	30
Corpus Luteum Cysts	7
Total	71

* From the Department of Obstetrics and Gynecology, Holzer Clinic, Gallipolis, Ohio.

sult of abdominal discomfort or pain. These represent the true corpus luteum cysts.

Ruptured Graafian Follicle

There were 16 cases diagnosed as representing rupture of a graafian follicle, 10 being proven at laparotomy. The remaining six had enough pain to require hospitalization but observation ruled out appendicitis or other abdominal emergencies. Though not proven, these cases were felt to represent rupture of a graafian follicle with the typical symptom complex of peritoneal irritation. This total does not include those diagnosed in the office or recognized by the referring physicians in our area and not hospitalized. We will speculate later on what the true incidence of the condition may be.

These 16 cases were analyzed in more detail for any available diagnostic guideposts and for comparison with the patients having ruptured corpora lutea. The average age of patients was 23, about half being married and almost half parous. The length of time since the previous menstrual period varied but most were within 12 to 17 days. The time to the next menses that actually occurred was more constant, the extremes being 11 to 16 days, with 80 per cent having their next period either 13, 14, or 15 days from the onset of symptoms.

In nine cases the onset of pain was sudden, in two fairly sudden and of a gradually increasing nature in the remaining five. Initial pain seemed to occur at any time of day and appeared to be unrelated to activity. Almost all patients noted some associated nausea but it was seldom severe and only four vomited. None of the patients complained of any bowel or urinary symptoms.

On examination all patients had normal blood pressure and pulse rates. Temperatures ranged from 99 to 100.8 degrees and averaged a slightly elevated 99.2 degrees. All had some degree of abdominal tenderness and about half exhibited rebound tenderness. Five demonstrated involuntary muscle guarding. All but three had pelvic tenderness but only four had any palpable adnexal mass.

Laboratory findings showed 11 of the 16 with white blood cell counts over 10,000 and the whole

group averaged 12,100 with 68 per cent polymorphonuclear leukocytes. Hemoglobins were normal in 75 per cent. The remainder ranged from 9.3 to 10.6 grams per 100 ml. but were apparently on the basis of iron deficiency anemia rather than any significant amount of hemoperitoneum. All urinalyses were normal.

The 10 operative cases all demonstrated some amount of blood in the peritoneal cavity but in no case was it estimated to be over 200 cc. There was a demonstrable ruptured follicle on the ovary in each case. Nine of the 10 were on the right ovary. Four were diagnosed preoperatively as a ruptured graafian follicle, two as appendicitis, two as ectopic pregnancy and two as being either appendicitis or a ruptured follicle.

Ruptured Corpus Luteum

There were 10 cases diagnosed as representing a ruptured corpus luteum. Eight were operated, two were discharged after hospital observation. These 10 were also analyzed for comparison with the cases of ruptured graafian follicles.

The average age of the patients was 26, most being married and half being parous. The length of time since the previous menstrual period varied from 22 to 29 days. The time to the next menses that actually occurred varied from six days to a few hours, but 7 of 10 began within 48 hours.

In 9 of 10 the onset of pain was sudden. It occurred postcoitally in two cases and with strenuous activity three additional times. Most patients noted nausea after the onset of pain and three vomited. One of two patients with a massive hemoperitoneum noted urinary frequency and diarrhea; no others had either symptom.

On examination all patients had normal blood pressures and pulse rates with the exception of the two patients with hemoperitoneum whose blood pressures were 98/60 and 90/70 with accompanying tachycardia. The average temperature was 98.8 degrees. All had abdominal tenderness; six had rebound tenderness and four involuntary muscle guarding. All but one exhibited pelvic tenderness but there were no palpable masses on bimanual examination.

On laboratory examination the average white

TABLE 2—Differential Diagnosis

	Ruptured Graafian Follicle	Ruptured Cystic Corpus Luteum	Ectopic Pregnancy	Appendicitis
Occur Prior to First Coitus	Yes	Yes	No	Yes
Last Normal Menstrual Period	12-17 days	22-29 days	Usually over 30 days	No relation
Abnormal Vaginal Bleeding	Rare	None	Frequent	None
Onset of Pain	Usually Sudden	Sudden	Sudden	Gradual
Abdominal Tenderness	Diffuse	Diffuse	Diffuse	Localizes
Pelvic Tenderness	Mild to Marked	Mild to Marked	Marked	Usually Absent
Pelvic Mass	None	None	Present	None
WBC	Av. 12,000 Decreases	Av. 12,000 Decreases	Varies	Over 14,000 Increases
Symptoms & Findings	Improve	Improve	Persist or Recur	Increase

blood cell count was 12,200 with 76 per cent polymorphonuclear leukocytes. Excluding the two cases of massive hemoperitoneum all hemoglobin levels were normal and there were no abnormalities on urinalysis.

The eight operative cases all demonstrated free peritoneal blood, two cases being estimated at 1500 cc. Bleeding sites from ruptured corpora lutea were noted in each instance although three had ceased bleeding. Two cases were diagnosed preoperatively as ruptured corpus luteum, two as hemoperitoneum from ectopic pregnancy or ruptured cyst and four as appendicitis. All eight cases operated involved the right ovary.

Differential Diagnosis

In table 2 we have attempted to present the main differential points between ruptured physiologic cysts, appendicitis and ectopic pregnancy in average cases. Some factors such as age, presence of nausea and vomiting, bowel and urinary symptoms, rebound tenderness, temperature elevation and hemoglobin levels are of little differential value.

Comment

The importance of accurate diagnosis of the ruptured follicle and corpus luteum is reflected in the fact that many times conservative treatment will be adequate and surgical intervention unnecessary. That these conditions are not uncommon can be noted by the occurrence of 27 ectopic pregnancies in the same interval that there were 18 laparotomies for ruptured cysts and presumably an equal number which were treated without surgery.

There is no apparent reason to assume that ruptured graafian follicles or corpora lutea should occur more often in one ovary than the other and yet in 18 operative cases 17 occurred in the right ovary. The report of Taniguchi and Kilkenny lists 14 of 19 and Claman 22 of 34 occurring on the right side. Among our true follicle and corpus luteum cysts without rupture, seven were located in the right ovary and 12 in the left. This suggests that the pathological change occurs as often on the left as on the right, but since symptoms and findings arising on the left do not suggest the common misdiagnosis of appendicitis, more conservative treatment is employed and such patients are not hospitalized.

If one considers physiologic cysts of the ovary, error will decrease. Previous reports listed only a rare case as diagnosed preoperatively. The proper diagnosis was made or listed together with one other possibility in 10 of 18 cases in this series. Appendicitis was the most common diagnostic error, only one patient in this category having

been seen by a gynecologist. Ectopic pregnancy was twice diagnosed mistakenly by a gynecologist.

Conservative treatment would appear to have been successful in eight cases in the present series plus the additional number we presume to have occurred. If surgery is required, conservatism is also indicated. In eight cases the cyst was excised from the ovary. In 10 cases the ovarian defect was simply sutured. In no case was oophorectomy necessary and all patients recovered uneventfully.

Summary

1. Twenty-two cases of true follicle cysts and 23 cases of cystic corpora lutea and corpus luteum cysts have been found in a total of 71 diagnosed.
2. Sixteen cases of ruptured graafian follicles and 10 cases of ruptured corpora lutea have been analyzed for diagnostic aids.
3. Seventeen of the 18 operative cases showed the ruptured cyst in the right ovary. The probable significance of this is discussed.
4. Differential diagnosis among ruptured graafian follicles, ruptured corpora lutea, tubal pregnancy and appendicitis has been outlined.

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"Staphylococcus Persistent"

The trouble with the staphylococcus is that it persists as well as resists.

At the American Public Health Association's annual meeting, Dr. Frank B. Engley, Jr., University of Missouri School of Medicine, said that staph's ability to withstand environmental stresses makes it the "most persistent of the non-spore-forming bacteria."

He noted that staph may remain viable in the body, in cultures, in foods and on various inanimate objects in hospitals for prolonged periods. Some examples:

Air—several hours after suspension; blood samples—9-19 years; pus—2½-3½ years; sputum—many days to months; culture—11-12 years; desiccated cultures—30 years.

Frozen eggs—1 year; meat—60 days; vegetables—8 months; distilled water—20-30 days; tap water—2-4 days; ice—up to 66 days; water plus body fluids—over 500 days.

Clothes—several months; paper—51-70 days; walls—100 days; instruments—86 days; wood—35-130 days; dust—months—*Ciba Medical News*.

Dermatologic Disease

A Case Report on Preventable Blindness

WILLIAM H. HAVENER, M.D.

A BLIND EYE is a serious loss to both patient and community. Awareness of the preventable nature of a significant portion of this blindness should help in reducing the incidence of such tragedies. The representative cases to be presented here are selected to emphasize relatively common causes of blindness which can in many instances be averted by proper, timely care.

Case Report

Despite a known previous allergic reaction to sulfonamides, this 56 year old man received sulfa medication for a urinary infection. The result was a severe exfoliative dermatitis, also affecting mucous membranes, especially the conjunctiva (Stevens-Johnson syndrome). Considerable conjunctival scarring resulted from the allergic reaction, and more developed through secondary infection. Although the dermatitis cleared within several weeks, extensive conjunctival and corneal scarring remained as a permanent residual. Vision was reduced to 20/100 and 20/50, and the severe continuing irritation and dryness of the eyes caused such marked photophobia and discomfort as to preclude any prolonged use of his eyes. It is now more than a year and a half since the allergic reaction, and this patient is still seriously handicapped visually.

Discussion

Eye complications are not uncommon in the serious generalized allergic mucocutaneous reactions. Fairly simple care during the acute stage will often minimize permanent residual ocular damage. Topical *steroid* ointments instilled every several hours during the day will decrease inflammation and scarring. Secondary infections are quite common in seriously inflamed eyes, and contribute a great deal to the permanent scarring. Topical ocular *antibiotics* (commercial combinations including bacitracin, neomycin, and polymyxin have an extremely broad antibacterial spectrum) can prevent these infections completely, and should be used prophylactically. Mydriatics may become necessary if iritis develops, but should not be employed prophylactically.

It is apparent that in this particular case the entire problem would have been avoided simply by not giving a medication to which the patient was allergic. Currently, the level of use of antibiotics is very high and large numbers of patients have become sensitized to one or another of these medications. It should be the physician's habit to inquire into possible allergy before prescribing antibiotics. Many patients make relatively unfounded statements about being "allergic," but if they describe a typical allergic skin rash, their statements should be credited. Even in doubtful cases, it is easy to select an alternate antibiotic from the large number now available.

The Author

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Acne rosacea is commonly associated with rosacea keratoconjunctivitis. This is a vascularized scarring which begins at the corneal periphery and very gradually encroaches centrally. Topical steroids are very effective in preventing this corneal scarring. Atopic eczema rarely will cause a rapidly developing cataract in a young person. It is reported that systemic steroids may control the severity of the dermatitis and arrest progress of the cataracts. Pemphigus may cause serious eye lesions, but no really satisfactory treatment exists.

Many old wife's tales exist concerning eye damage resulting from the acute exanthemata of childhood. It is true that the rare cases of post-infectious encephalitis may damage the visual tracts, but the acute virus infections themselves do not cause significant eye pathology. It is granted that follicular conjunctivitis accompanies many of these infections, and that a punctate keratitis with photophobia is common in measles, but these cause no permanent damage. The onset of strabismus is sometimes blamed upon these childhood virus infections, and they probably can be a precipitating factor, nevertheless, the underlying hereditary muscle imbalance is still the real culprit. Prohibiting reading and watching television during a case of measles has no sound medical basis and certainly makes time pass more slowly for the bored child and the harassed mother.

Tuberculosis patients number 4,510,000 in Japan — 3.3% of total population. TB, which ranked among the top killers in Japan until a decade ago, is on a steady decrease, however. Number of patients is down 20 per cent from 1953.



MATERNAL HEALTH IN OHIO

Case No. 70

This 38 year old, white, primigravida expired approximately five hours after aborting a pregnancy of eight weeks' gestation. Her past history was not remarkable. The patient had been a sterility problem for eight and one-half years, otherwise there had been no physical or menstrual abnormality. In March, prior to her death, a dilatation and curettage was performed and a "stem pessary inserted." Last menstrual date was not recorded. She became pregnant and was seen by her physician for "three prenatal visits," at which times urinalyses, abdominal examinations and blood pressures were all normal.

At about 10 a. m., August 30, she started to bleed. At 1:00 a. m. she was admitted to the hospital bleeding profusely. Blood pressure on admission was 90/60. Dextran was started. Ten minutes later her blood pressure had dropped to 65/40. She was taken to surgery and under Pentothal® and nitrous oxide, a "dilatation and curettage and packing" was performed. At 2:00 a. m. products of conception were removed from the cervix.

As the patient was being returned to her room she suddenly became cyanotic. Her blood pressure dropped from 90/48 to 0/0. She was intubated and given oxygen. Suspecting a cardiac arrest, the chest was opened and resuscitative measures, that is, cardiac massage and defibrillation was instituted. The patient was pronounced dead at 5:18 a. m.

Pathological diagnosis: Air embolism to the pulmonary circulation (Coroner's report). Four cm. fetus, placental tissue and decidual tissue seat of focal necrosis and acute inflammation (pathological report on products of conception).

Comment

The Committee was quite interested in certain aspects of this case. First, it would like to know what type of stem pessary was used; how it was anchored, and when was it removed from its placement, presumably in the cervix. Again, it would be helpful to know more about the pathologic findings of the tissues other than the lungs. Committee members voted this a nonpreventable maternal death, based upon available information.

Case No. 173

This patient was a 26 year old Para III, abortus I, who expired about four days after she started to abort a pregnancy of six weeks' gestation.

Past history and past pregnancies apparently were non-contributory. Little could be learned about her previous three term-pregnancies. Her last menstrual period was said to have been eight weeks prior to admission to the hospital. On June 27 the patient was admitted to the emergency room complaining of dyspnea, vomiting, abdominal cramps and vaginal bleeding of approximately four days' duration; she had passed many clots earlier

TOPIC THIS MONTH:

Maternal Deaths* Involving Air Embolism

that day. Blood pressure was 124/60; slightly weak pulse 160; temperature 98, on admission. There was marked tachycardia, otherwise the heart and lungs were normal. Pelvic examination revealed an enlarged uterus with a dilated cervix. A piece of tissue was found in the vagina.

She was treated with oxytoxics, antibiotics and stimulants, but death ensued before blood transfusion could be started—less than two hours after arriving in the emergency room. Autopsy was performed.

Pathological diagnosis: Air embolism; post-abortion myometritis and thrombophlebitis with multiple pulmonary emboli; acute post-hemorrhagic anemia; recent abortion; pleural adhesions, right costophrenic angle.

Comment

The Committee voted this case a nonpreventable maternal death, by a narrow margin. It was pointed out that earlier treatment of the incomplete abortive phase of this pregnancy with antibiotics, dilatation and curettage after prompt blood replacement, might have altered the course of the case. An infection can be treated, after blood replacement saves the life; the converse situation is futile. Committee members debated at length as to whether or not this was *really* a fatal pulmonary air embolus!

Case No. 109

(A "non-maternal" death is added for comparison)

This was a 26 year old, white, cesarean II, who died 227 days postpartum (postcesarean). Past history revealed an appendectomy in 1943. Cesarean section performed seven years ago for cephalopelvic disproportion. There were no complications.

Her last menstrual period was September 21, as she registered with her obstetrician in the second month. Her prenatal care for the first four months was considered

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by official representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

adequate. She was hospitalized for tuberculosis, February 20, at 21 weeks gestation, and the remainder of her prenatal care was performed at the sanatorium. She was delivered by cesarean section, June 25, an elective, low-flap operation at 39 weeks, no labor. The baby was healthy and the operative and obstetric course of the patient was uneventful.

On January 25, (30 weeks postcesarean) she had a segmental resection of the right upper lobe for a tuberculosis cavity. On February 7, following an aspiration of a small pneumothorax cavity in the right apex, the patient suddenly collapsed in shock, and death ensued in about one hour. Cardiac massage was unsuccessful. Permission for autopsy was obtained.

Pathological diagnosis: Air embolus. Post-needling of chest; pulmonary tuberculosis—14 months.

Comment

This death was considered not to be related directly to the pregnancy. The Committee voted this case a non-maternal death, (not connected with the pregnancy). However, due consideration was given to the possibility that the tuberculous lesion could have been accelerated by the presence of the gestation.

Comment of Consultant

The following comment of a consultant, who is a specialist in Pathology, was given at the request of the Committee.

Air embolism may lodge in either pulmonary or systemic vessels. Pulmonary air embolism reaches the right heart by way of the vena cava. The amount of air is relatively large and the activity of the right ventricle whips it and blood into a bright froth which fills the right heart and large pulmonary vessels and plugs and obstructs smaller pulmonary arteries and capillaries. This is best demonstrated on the fresh unembalmed body by opening the heart in situ under water.

Air may enter the uterus incidental to cesarean section, version or manual extraction of the placenta. However, its entrance into uterine veins is favored by uterine contraction around a pocket of trapped air. Insufflation or irrigation of the uterine cavity incidental to curettage can also serve to introduce air into uterine veins. It is further conceivable that a large uterine or pelvic vein, severed or lacerated, and held open by attachments to surrounding structures, might become filled with air as a result of negative pressure in the vein in association with cardiac filling or movements of respiration.

The circumstances in Cases No. 70 and No. 173 are not classical of air embolism. Case No. 70 was in shock and could have expired from *blood loss*. Cardiac massage might well have confused the autopsy findings. Case No. 173 was noted to have acute posthemorrhagic anemia, postabortal myometritis and thrombophlebitis with multiple pulmonary emboli. In the absence of a descrip-

tion of autopsy technique and findings it is difficult to feel entirely satisfied with the diagnosis of air embolism in *either* of these cases.

Systemic air embolism results from entrance of air into a pulmonary vein in association with injection, aspiration, or operation involving the chest. The amount of air is usually not great. It reaches the left heart and seems to pass out easily and quickly and may produce important consequences if it lodges in coronary or cerebral arteries.

The autopsy demonstration is difficult and often speculative. It may be possible to demonstrate air in coronary vessels by examining the heart in situ under water. Otherwise, air bubbles may well have entered coronary vessels as the heart was removed. It is practically impossible to expose the brain without allowing the possibility of air entering cerebral vessels in the process. The evidence is therefore often circumstantial rather than direct. The clinical circumstances in Case No. 109 are fairly typical, but the autopsy demonstration was compromised by cardiac massage.

In a large measure, these three cases of possible air embolism are representative of my own experience with this entity in that more often than not the autopsy diagnosis is not entirely clear-cut and satisfying.

Problems in Evaluation of Tranquilizing Agents

Evaluation of tranquilizing drugs is more difficult by any technique than evaluation of drugs given for purely organic effect, since both the symptom and its evidences are conditioned by profound psychic values. Difficult as it is to match psychiatric patients as controls, it is equally difficult to use each patient as his own control, since his reaction either to drug or to placebo may be strongly affected by previous experience with the other dose or with other drugs.

In a "double blind, double cross" test comparing the values of prochlorperazine and phenobarbital, the controller misled the observers by maintaining the same drug for each patient during the entire test period. The observers detected that the test was not going according to plan, and when the "double cross" was revealed they were able to guess fairly well which patients had received each drug.

The experiment not only sharpened their future observation, but demonstrated the reliability of trained clinical judgment in evaluating drugs when bias is eliminated.—Sidney Cohen, M. D., Los Angeles: *California Med.*, 89:417, December, 1958.

A Clinicopathological Conference

Edited Under the Auspices of the Ohio Society of Pathologists

CHARLES BLUMSTEIN, M.D., *President*

Presentation of Case

THE patient, a Negro male, first entered University Hospital, Columbus, Ohio, at the age of 36 years, complaining of dyspnea for the preceding four days. He stated that for one year prior to admission he had been experiencing vague transient substernal discomfort lasting usually two to three minutes and relieved by antacids. For two weeks prior to admission he had had a productive cough.

On physical examination the patient appeared in acute distress with marked dyspnea, orthopnea and diaphoresis. His blood pressure was 130/108; he was tachypneic and his speech was breathless. His heart extended 9.5 cm. to the left of the mid-sternal line; P_2 was greater than A_2 . His liver was palpable 4 cm. below the costal margin, and there was 1 plus pretibial edema.

All laboratory tests including sickle cell preparation and Congo red tests were negative. The chest x-ray showed marked cardiac hypertrophy and dilatation with bilateral pulmonary hyperemia and congestion. Serial electrocardiograms were indicative of left ventricular hypertrophy. The patient was digitalized and given aminophylline, phenobarbital, mercurhydrin and ammonium chloride and a diet containing 200 mg. of sodium. He improved and lost 25 pounds in weight. The etiology of the heart disease was not determined. The patient was much improved on discharge.

Two Years Later

His second admission came two years later, with a chief complaint of exertional dyspnea and a history of chest pain which had occurred every two to three weeks for the past eight months. He was referred from another hospital because of the absence of hypertension and of a rheumatic history. His chest x-ray showed a 30 per cent increase in the transverse cardiac diameter, and the pulmonary parenchyma appeared congested. Again all laboratory tests, including protein-bound iodine and cholesterol, were negative and his electrocardiograms showed left ventricular enlargement and myocardial changes. At this admission it was recorded that members of the patient's family had died of cardiac disease and that the patient's

Presented by

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brother also had cardiac enlargement. The patient was given trial therapy with thyroid, 15 mg. daily, and was discharged to the cardiac clinic for further digitalis therapy.

On his third admission, nine months later he showed exertional dyspnea and signs of congestive heart failure. His blood pressure was 118/84. The heart rate was 80 per minute and regular. The patient was moderately orthopneic. His heart showed the position of maximum impulse at the anterior axillary line. There was 1 to 2 plus pitting edema of the extremities. The electrocardiograms showed left ventricular hypertrophy and myocardial changes. The patient showed a good response to digitalis and diuretics and lost 8 pounds in weight. His orthopnea disappeared, his exertional dyspnea was much improved and his appetite was good when he was discharged on his tenth hospital day.

Twenty-one months later he was again admitted for treatment of congestive failure. Since his last hospital discharge he had been feeling fairly well with only minimal exertional dyspnea. One day prior to admission he awoke very dyspneic and continued in severe distress until his admission. His blood pressure was 120/90, his pulse was 100 and regular. His heart was enlarged to the anterior axillary line and showed an auricular diastolic gallop rhythm. There was no peripheral edema. The stool was guaiac negative. The van den Bergh was 0.3/1.0 mg. The patient was treated with digitoxin, ammonium chloride and mercurhydrin. He lost 8 pounds of weight and was discharged to be followed in the cardiac clinic.

Fifth and Final Admission

His final admission was seven months later, four years after his first hospitalization. He had had bouts of chest pain relieved by nitroglycerin.

Three weeks prior to admission he had the "flu" and was in bed. Since then he had had an increase in his exertional dyspnea, paroxysmal nocturnal dyspnea and orthopnea. The day of admission his pulse was 112. He showed a picture of peripheral vascular failure with diaphoresis and was admitted as an emergency case.

Physical Examination

The patient appeared well nourished, slightly dehydrated, dyspneic and in acute distress. His blood pressure was 108/70, his pulse 108, his respirations 30 and his temperature 99°F. A few scattered rales were heard at both lung bases. There was an increased anteroposterior diameter of the chest and hyperresonant note on percussion over all. The heart was enlarged to the anterior axillary line, a diastolic gallop rhythm was present but no murmurs were audible. The liver was four fingerbreadths below the right costal margin and was slightly tender. There was 2 plus edema from toes to knees.

Laboratory Examination

His urine analysis and peripheral blood counts were within normal limits. The serology was negative for syphilis. The sodium was 147 mEq., the potassium 4.8 mEq. and the chlorides 109 mEq. The electrocardiogram showed complete left bundle branch block with the possibility of an anterolateral myocardial infarction. It showed considerable changes from the previous records. Chest x-ray showed an ill-defined opacity in the right lower medial lung field suggestive of pneumonia. There was a slight increase in the heart size from the last film seven months previously.

Hospital Course

During his stay the patient was on a 500 mg. salt diet. His weight remained essentially unchanged. He was continued on digitalis, Peritrate® and Diamox.® On the second hospital day his temperature rose to 100°F. and he continued to have a low-grade pyrexia until his death. He was very weak, was eating poorly and sweating heavily. On the fourth hospital day he was found with an unrecordable blood pressure and an imperceptible pulse. After Neo-Synephrine® his blood pressure rose to normal levels but the patient was now disoriented. His heart showed a systolic apical murmur and a diastolic gallop rhythm. The electrocardiogram showed a complete left bundle branch block with low amplitude R in V5, evidence thought to favor acute cardiac infarction. A few hours later his heart sounds became inau-

dible and respirations ceased. He died on the fourth hospital day.

Clinical Discussion

DR. WALL: This man was aged 40 when he died and was 36 when he first got acutely sick with a four-day history of dyspnea. His preceding symptoms are obvious evidence of left ventricular failure, or at least congestive failure with most of it appearing to be left ventricular. His productive cough may very well have been related to incipient pulmonary edema, I would think. He was not hypertensive but his heart was tremendously enlarged. This man was apparently in severe respiratory difficulty with left ventricular failure. They put him through a whole gamut of tests, without adding much to our knowledge of the patient. He obviously had no sickle cell trait, no lupus erythematosus and no syphilis, which are all important factors to be ruled out. They digitalized him and he got along for the next 14 months.

The patient was again admitted after two years with left ventricular failure, exertional dyspnea and chest pain which occurred every two to three weeks and which was probably anginal in origin. There was no evidence that he had had any hypertension in the past, but I suppose he could have had hypertension which a recent myocardial infarction would cover up. His heart was now increased 30 per cent in transverse diameter. Since there was no good evidence of hypothyroidism, he was cautiously given ¼ grain of thyroid. People who are suspected of having myxedema heart disease should be started on the smallest possible dose of thyroid because if the dose is too high they go into rapid, intractable failure since their metabolism is increased while their myocardium still remains too sick to stand the strain.

He came in nine months later and apparently he had been in mild in-and-out failure since his discharge. His orthopnea had increased, he was short of breath on exertion and he was still normotensive. His heart was possibly a little bigger, and still they could not hear anything abnormal in his heart. His electrocardiograms showed left ventricular hypertrophy and also had some myocardial changes, part of which might be a digitalis effect. He improved after digitalis and diuretics but came back 21 months later, again in failure. Again there was nothing too remarkable in his laboratory tests. His stool was guaiac negative and he was not jaundiced chemically or otherwise. He again lost some weight, felt better and went back to the cardiac clinic.

Final Admission

He came in for the fifth and last time and still I imagine no diagnosis had been made of his heart

condition, which in an academic institution I am sure must be frustrating to one's pride. He now had frequent anginal pain which was relieved by nitroglycerin, and then he had apparently a "flu-like" episode which threw him into failure and he had to be admitted as an emergency in acute distress. His blood pressure was a little lower than it had been previously. His pulse and his respirations were up and he was possibly a little febrile. His heart was probably at least as large as before, and he had a diastolic gallop such as we might hear in somebody in failure. His laboratory studies were not remarkable. He had a left complete bundle branch block, and whenever we have a left bundle branch block in a person like this with an acute change in his clinical picture we must consider the possibility that he might have had an acute myocardial infarction partially hidden by this left bundle branch block.

His blood pressure started falling, he was sweating heavily and Levophed® apparently did not work too well. His electrocardiogram showed complete left bundle branch block with low amplitude, which was thought to be possible myocardial infarction. He seemed to die from cardiac failure, possibly with superimposed infarction, but I can't believe that he had intrinsic coronary disease during his entire illness. It is hard to believe that this was a prime problem. What could he have had? I shall ask Dr. Elson to review all his x-ray pictures before I stick my neck out.

Review of Roentgenograms

DR. ELSON: The first film, in 1953, showed the heart markedly enlarged in transverse diameter and a heavy diffuse pulmonary opacification as commonly found in pulmonary edema. After a few days of cardiac treatment the heart decreased in size and the pulmonary edema disappeared. In 1954 the heart appeared again increased in size and again we have the poorly defined opacification of pulmonary edema. The heart increased and decreased in size with treatment of the patient and in the last film, taken in 1956, there is again evidence of pulmonary edema and we have the largest heart size as yet observed in this patient.

With this sort of change in the heart size several things come in mind. About the first thing one thinks of is pericardial effusion, but fluoroscopy, physical examination and EKG speak against such a diagnosis. The next thing of course would be some myocardial disorder as one sees sometimes in children, where there is rapid enlargement of the heart followed by rapid decrease as the disease is treated. It is a little unlikely to see this

sort of rapid change with plain myocardial infarction or with rheumatic heart disease. Another thing that comes to mind is endocardial fibroelastosis. Against this is of course the patient's age, since it usually occurs in younger patients, very often in children. So in conclusion, we have a patient whose heart shows rather diffuse enlargement without any specific chamber being singularly enlarged, rapid changes in heart size, and no good evidence of pericardial effusion. Pulmonary edema was seen several times.

DR. WALL: We are left again with the diagnosis of some form of myocardial disease as our best bet. We have no evidence of syphilis, chronic anemia, hyperthyroidism, emphysema, valvular disease, hypertension, and only a remote possibility that he could have coronary artery disease. What are some of the other things that could cause this kind of heart disease and how can we exclude them?

I don't believe this is myxedema heart. The basal metabolic rate and the lack of anemia and of other stigmata of myxedema are against it. The cholesterol was not markedly elevated and people with myxedema heart disease do not have orthopnea. They also usually have a very low voltage EKG. A remote possibility is an arteriovenous fistula distant from the heart. However, I would think that we would have a history of trauma, knife or pistol wound, since a spontaneous AV fistula is extremely rare. The lack of murmur would exclude a ruptured heart valve. He had no nutritional history to suggest beriberi heart disease.

Rare Conditions?

Could he have a cor pulmonale as a consequence of pulmonary infarctions? The main factor against it is that he does not seem to have primary right heart disease. Does he have scleroderma of the heart? It has been reported without any other stigmata of the disease, but it would be an awfully rare bird. Could he have a tumor of his heart? Primary tumors of the heart are very rare and usually cause a very peculiar eccentric enlargement of the heart rather than a generalized cardiomegaly. I think time and observations would be against lupus erythematosus, and most of these people have valvular disease as well as pericarditis. Addison's disease sometimes causes a heart disease seldom thought of, but these people have a small heart. I think we can exclude kyphoscoliotic heart disease since he did not have a deformed chest. Amyloid disease of the heart is also very rare and I don't believe we have any objective evidence of it. He had no evidence of primary amyloidosis

such as macroglossia, and his Congo red test four years ago was negative.

Another rare condition is carcinoid of the small intestine, in which serotonin secretion usually causes heart failure. However, this is of such progressive nature that it does not last four years, and these people also have all kinds of abnormal vasomotor reactions. Marfan's syndrome may also be mentioned, but this man had a little aorta, never had any lens changes, his body build is not typical of Marfan's syndrome, and his fingers were not of the arachnodactyle type. William Evans¹ in London reported a group of cases of familial cardiomegaly in two families that went on to progressive failure. This is the only familial incidence that I know of, and consisted of idiopathic familial cardiomegaly with slowly progressive failure.

Adult Form of Fibroelastosis

All this still leaves us with a diagnosis of chronic myocardosis, which 20 years ago would have been called chronic myocarditis. I think this man has generalized myocardial disease and I don't believe he has any of the ones I mentioned unless it is the so-called Evans syndrome of familial cardiomegaly. So I will say then that our patient suffered from chronic myocardosis simulating an adult form of fibroelastosis, in which the actual pathological findings will probably be those of fibrosis of the myocardium, possibly with some Fiedler's type of myocarditis, but without valvular disease. I think his last episode was quite possibly a myocardial infarction. We don't have chemical evidence of it, but we have suggestive evidence in his sudden type of fatal heart failure, while his existing left ventricular block makes it a little bit difficult to be too sure of this diagnosis.

Clinical Diagnosis

1. Chronic myocardosis of undetermined origin.
2. Congestive heart failure.
3. Terminal myocardial infarction.

Pathological Diagnosis

1. Endocardial fibroelastosis.
2. Congestive heart failure.
3. Chronic pancreatitis.
4. Chronic pyelonephritis.

Pathological Discussion

DR. VON HAAM: I selected this case for discussion because the clinical diagnosis was that of cardiomegaly of undetermined origin, and the autopsy indeed showed that the patient had a very large heart. It weighed 830 grams and extended to the left midaxillary line. All chambers were

dilated, especially the right atrium and both ventricles. There was no evidence of any valvular disease. However, the mural endocardium showed large plaques of thick whitish areas of fibrosis measuring up to 2 cm. in diameter. Over 20 of these could be noted in the left ventricle and five in the right ventricle.

Dissection of the heart muscle showed a soft, pale muscle with some mottled pink yellow areas, and two fibrous scars located in the lateral wall of the left ventricle. The coronary vessels appeared perfectly normal and showed no more than 5 per cent obstruction of the lumen by arteriosclerosis. The remaining organs showed evidence of congestive heart failure with heavy, edematous lungs with compensatory emphysema, and an enlarged, congested liver.

Microscopic Examination

Sections through the heart showed marked thickening of the mural endocardium with fibrosis of the underlying heart muscle. Special stains revealed a tremendous increase in the number of elastic fibers which formed a very dense network in the thickened endocardium. Fat stains revealed an irregular fatty degeneration of the heart muscle fibers, particularly manifest in the right ventricle. The myocardial fibrosis appeared non-specific and was most pronounced in the subendocardial layers of the heart muscle. Sections through the coronary vessels showed a minimal amount of arteriosclerosis without narrowing of the lumen. Microscopic section of the remaining organs showed mild chronic pyelonephritis and interstitial pancreatitis and evidence of chronic congestive failure.

We feel then that we are dealing with one of those unusual cases of endocardial fibroelastosis in the adult as reported in 1952 by Johnson.² It seems that a small number of these cases live with this condition through their childhood and develop congestive failure as adults. As far as the etiology of the fibroelastosis is concerned, we are of course quite uncertain about it, but we believe that it is probably not related to fetal endocarditis but rather is a consequence of early and mild anoxia of the myocardium. Johnson pointed to the fact that most of these cases had cardiac anomalies in which some degree of anoxia of either one or both ventricles could be postulated, even if it was simply a case of premature closure of the foramen ovale. I believe therefore that this patient died of congestive heart failure as a consequence of fibroelastosis of the heart.

References

1. Evans, W., quoted by Levine, Samuel A. in: *Clinical Heart Disease*. Philadelphia, W. B. Saunders Co., 1958, p. 184.
2. Johnson, F. R.: Anoxia as a Cause of Endocardial Fibroelastosis in Infancy. *Arch. Path.*, 54:237-247, 1952.

Proceedings of The Council

Budget for 1959 Adopted at December 13-14 Meeting; Anticipated Proposals in Next Legislature Reviewed; Other Business Transacted

MEETINGS of The Council of the Ohio State Medical Association were held in the Columbus office on Saturday evening, December 13, and Sunday, December 14, 1958. All members of The Council were present except Dr. Carl A. Gustafson, Youngstown, who could not attend because of illness. Others attending were Mr. Wayne E. Stichter, Toledo, legal counsel; Dr. Charles L. Hudson, Cleveland, chairman of the Committee on Medical Services; Dr. C. C. Sherburne, Columbus, one of the OSMA Delegates to the AMA, and members of the Columbus office staff.

On motion duly made, seconded and carried, the minutes of meetings of The Council held at Granville, Ohio on September 12-14 were approved.

Dr. Woodhouse opened the meeting by urging all members of The Council to urge secretaries of county societies to report new officers and committee chairmen to the Columbus office promptly so invitations can be sent as soon as possible to those expected to attend the Conference of County Society Officers and Committeemen in Columbus on February 22, 1959. He called attention to the red handbook which will be sent to new presidents and secretaries; and he recommended that the Councilors endeavor to get more county societies to adopt the "model" constitution and by-laws for local societies.

Membership Data

The Executive Secretary reported membership figures as follows: OSMA members as of December 10, 1958, 9,206, of which 36 are in military service and 338 retired, none of whom pay dues. This is a net increase of 136 members during the year.

With respect to AMA members, the report showed that 8,165 members of the OSMA are affiliated for 1958 with the AMA, compared to 8,030 in 1957.

1959 County Society Officers Conference

A program suggested by the Executive Secretary for the County Medical Society Officers and Committee Chairmen Conference on February 22 at the Deshler-Hilton Hotel was approved by The Council.

Officers of the Association were instructed to

invite Governor DiSalle to the meeting as a luncheon guest and to invite him to make a short address to the conference if he cared to do so.

Dr. Arthur G. James, Columbus, chairman of the Cancer Committee of the Ohio State Medical Association, Dr. Carl A. Wilzbach, Cincinnati, and Dr. A. E. Rappoport, Youngstown, members of that committee, appeared before The Council, on invitation, to discuss the possibility of legislation to protect those reporting cancer to cancer registries from prosecution on charges of violating the confidential communications statutes.

Following their presentations, The Council officially voted to support legislation which would protect those reporting cancer cases to a bona fide cancer registry, providing the proposed law did not make the reporting of cancer compulsory.

Charter to be Reissued

By official action, The Council approved the issuance of a reissued charter to the Madison County Medical Society, which had mislaid the original charter issued to them.

Amendments and New Constitutions Acted Upon

Belmont County—Amendments adopted by the Belmont County Medical Society at the October, 1958, meeting of that society were approved by The Council by official action.

Delaware County—A new constitution and by-laws adopted by the Delaware County Medical Society on January 21, 1958, -was officially approved.

Henry County—A new constitution and by-laws adopted by the Henry County Medical Society on October 1, 1957 was officially approved.

Muskingum County—A new constitution and by-laws adopted by the society on November 4, 1958, was officially approved.

Madison County—The Council voted to approved the new constitution and by-laws submitted by the Madison County Medical Society to the OSMA on December 2, providing the Madison County Medical Society agrees to several minor corrections in the wording.

Guernsey County—The revised constitution and by-laws of the Guernsey County Medical Society, adopted by the society on September 4,

1958, was not approved, pending necessary corrections recommended by The Council.

Budget for 1959

A report from the Committee on Auditing and Appropriations was presented by Dr. Artman. The committee's report was officially approved, including the following budget for 1959:

The Ohio State Medical Journal	\$ 40,000.00
Executive Secretary, Salary	17,500.00
Executive Secretary, Expense	2,000.00
Administrative Assistant, Salary	9,600.00
Administrative Assistant, Expense	1,500.00
Stenographic and Clerical Salaries	36,500.00
President, Expense	1,200.00
President-Elect, Expense	500.00
Council, Expense	4,000.00
American Medical Association Delegates ..	6,500.00
Dept. of Public Relations (\$37,500.00)	
Director, Salary	15,000.00
Director, Expense	2,000.00
Assistant Director, Salary	11,100.00
Assistant Director, Expense	2,000.00
Exhibits and Newspaper Publicity	1,000.00
Literature	1,000.00
Postage	2,500.00
Supplies	500.00
Miscellaneous Activities	3,000.00
Committees:	
Education	250.00
Judicial and Professional Relations.....	400.00
Public Relations and Economics	700.00
Scientific Work	750.00
Committees:	
Auditing and Appropriations	950.00
Cancer	250.00
Care of the Aged	500.00
History and Archives	250.00
Hospital Relations	400.00
Industrial Health	350.00
Laboratory Medicine	500.00
Maternal Health	1,500.00
Medical Services	500.00
Mental Hygiene	250.00
Poison Control	500.00
Rural Health	3,000.00
School Health	1,500.00
Traffic Safety	500.00
Miscellaneous	500.00
Annual Meeting	20,000.00
Conference of County Society Presidents- Secretaries	1,500.00
Emergency and Equipment Fund	5,322.80
Employee Retirement Fund	5,577.20
Insurance, Bonding, Social Security	4,500.00
Lectures for Senior Medical Students	3,500.00
Legal Expense	7,000.00
Library	250.00
OSMAgram	3,500.00
Postage	2,000.00
Professional Relations Activities	2,600.00
Rent and Utilities	11,800.00
Rural Medical Scholarships	2,000.00
Stationery and Supplies	3,500.00
Telephone and Telegraph	3,000.00
Woman's Auxiliary Contribution	1,500.00
TOTAL	\$248,500.00

During the discussion of the budget for 1959, The Council adopted a motion authorizing an

annual contribution of \$1,500.00 to the Woman's Auxiliary.

Annual Meeting

There was a discussion of time and place for the 1964 Annual Meeting so that suitable facilities would be available at that time. Inasmuch as the dates open in Cleveland that year do not seem to be acceptable, the Executive Secretary was authorized to get in touch with the Columbus Convention Bureau as to possible dates for a meeting of the Association in Columbus in 1964.

A communication from Marvin W. Shapiro, D.S.C., President-Elect of the American Podiatry Association, Toledo, requesting space in the 1959 scientific exhibit, was discussed. It was the feeling of The Council that all available space would have to be used for exhibits by members, medical institutions and allied health organizations.

Setup in Legislature

Mr. Saville then presented a report on the personnel of the next Legislature and of the next Congress, both of which will convene early in 1959. He pointed out that there will be many new members in both the House and the Senate of both bodies. This means, he told The Council, that there will be many inexperienced legislators and that it will be necessary for representatives of the medical profession to work harder than in the past in presenting the medical viewpoint on pending bills.

Health Department Proposals

Dr. Ralph W. Dwork, Director of the Ohio Department of Health, appeared before The Council, by invitation, to discuss bills which will be actively sponsored by the Department and other public health measures which may be presented to the Legislature.

Anticipated Legislative Proposals

Mr. Saville and Mr. Nelson presented a review of anticipated medical and health legislation during the 1959 session of the Ohio General Assembly.

Reports from Committees

Reports of the following committees were accepted and officially approved, including various recommendations made by the committees:

Industrial Health and Workmen's Compensation—Minutes of meeting held on November 16. (See Page 214)

Poison Control—Minutes of meeting held on September 24. (See Page 227)

Traffic Safety—Minutes of meeting held on September 28. (See Page 224)

Members of The Council Pose During December Meeting



Members of The Council, and others, are shown here as they attended the December meeting in the Columbus headquarters office. Left to right, seated: Drs. H. T. Pease, Eleventh District; Frank H. Mayfield, President-Elect; George A. Woodhouse, President; Robert S. Martin, Immediate Past-President; Paul F. Orr, Fourth District; and Geo. J. Hamwi, Treasurer.

Standing, left to right: Mr. Wayne E. Stichter, Legal Counsel; Dr. Robert E. Hopkins, Seventh District; Mr. George H. Saville, OSMA Public Relations Director; Drs. George W. Petznick, Fifth District; Floyd M. Elliott, Third District; C. L. Pitcher, Ninth District; Dean R. Dooley, Second District; Wm. D. Monger, Eighth District; Charles W. Hoyt, First District; Edwin H. Artman, Tenth District; Charles L. Hudson, Past-President and AMA Delegate; C. C. Sherburne, Past-President and AMA Delegate; and Mr. Charles S. Nelson, OSMA Executive Secretary. Absent because of an injury was Dr. C. A. Gustafson, Sixth District Councillor.

Mental Hygiene—Minutes of conference held on November 2.

Laboratory Medicine—Minutes of meeting held on December 7. (See Page 226)

Rural Health—Minutes of meeting held on September 24. (See Page 215)

Care of the Aged—Minutes of meetings held on October 19 and November 19. (See Page 228) In approving this committee's report, The Council urged the committee to get started at the earliest possible time on consideration of possible voluntary health insurance designed primarily for aged persons, suggesting the possibility of a conference in the very near future with representatives of Blue Cross, Blue Shield and insurance companies.

Changes In Health Laws

Mr. Saville presented the report of the Committee on Public Relations and Economics which was approved by The Council. It covered a study

of suggestions made by the Butler County Medical Society for changes in the laws pertaining to the appointment of district boards of health. The recommendations included appointment of such boards by county commissioners instead of the present system of having the board selected by district advisory boards composed of village mayors and chairmen of township boards of trustees.

The report pointed out that after conferences with representatives of various groups, private and public, interested in public health, the committee could find no unanimity of opinion as to the desirability of the changes suggested as a feasible solution to the problem of obtaining competent persons to serve on district boards of health.

The Butler County Medical Society was commended by the committee for its interest in the public health problems of the county. The hope was expressed that this will stimulate all county medical societies to evidence a greater interest in

the appointment of competent persons to district boards of health, as well as in the financing and other problems of local health departments.

The committee recommended to The Council that the Ohio State Medical Association sponsor a resolution at the coming session of the Ohio General Assembly requesting that the Legislative Service Commission make a study of the present procedure of appointing districts boards of health and the method of financing district health departments, and make recommendations for improving the setup.

Migrant Laborers

On the subject of payment for medical and hospital care of migrant laborers, the committee recommended that county medical societies which have this problem establish a liaison promptly with the county welfare departments so that a plan for its solution can be agreed upon well in advance of the time the laborers report for work.

It was pointed out that there is nothing in the Ohio poor relief laws to make a migrant or transient ineligible for poor relief, including the provision of medical and hospital care for those who cannot afford to pay for it themselves.

A suggestion from a representation of the Wood County Medical Society that employers of migrant workers be compelled by law to carry health insurance on these workers and their dependents was disapproved by the committee for the reason that it would be discriminatory and contrary to the policy of the Ohio State Medical Association in opposition to compulsory health insurance in general.

1962 AMA Rural Health Conference

By official action, The Council voted to invite the American Medical Association to hold the 1962 AMA National Conference on Rural Health in Columbus.

AMA Session in Minneapolis

A detailed report on the recent interim session of the AMA in Minneapolis was presented by Dr. Hudson, Dr. Sherburne and Dr. Woodhouse. (See January, 1959, issue of *The Journal* for story on meeting.)

AMA Public Relations Campaign

The question of participation at this time in the AMA Public Relations campaign on free choice of doctor was discussed. The Council was advised that a final decision on this question had not as yet been made by the AMA House of Delegates and that the matter will be brought up at the June, 1959, session of the AMA. For this reason The Council felt that no action should be

taken by it at this time and it ordered this subject held over for discussion at a future meeting.

Diet and Nutritional Quackery

A request from the AMA that the Association participate actively in the AMA campaign against diet and nutritional quackery was referred to the Committee on Public Relations and Economics for discussion and recommendations.

OMI Nominating Committee

The President was authorized to appoint a nominating committee to recommend nominees for the Board of Trustees of Ohio Medical Indemnity to be voted on by The Council at its February meeting.

Report on AMEF Campaign in Ohio

Reporting for Dr. Merrill D. Prugh, Ohio Chairman for the American Medical Education Foundation, Mr. Saville stated that as of November 30, 1958, Ohio contributors to the 1958 AMEF campaign numbered 824, for a total of \$30,340.92. Comparable figures for 11 months in 1957 were 529 and \$24,652.94.

Scholarship Project

A request from the National Foundation, that the Association nominate three physicians from whom one will be selected by the Foundation to serve on a scholarship committee, was discussed. The President was authorized to nominate three physicians as requested. A committee will select students to receive scholarships in five fields, namely, medicine, nursing, physical therapy, occupational therapy, and medical social work. The communication pointed out that Ohio will be eligible to receive four scholarships in each category—a total of 20 annual scholarships, each scholarship totaling \$500.00 a year for four years.

Policy on Use of OSMA Addressograph

The Executive Secretary requested The Council to review a situation which has developed with respect to the use of the addressograph of the Association in addressing envelopes for various individuals and organizations. He pointed out that this had become a serious problem with respect to deciding when this service should be supplied and when not; and in the use of the time of the personnel of the Columbus office.

Following a discussion, by official action, The Council adopted the following policy: The addressograph shall be used solely for addressing of material on the activities and programs of the Ohio State Medical Association and for the addressing of communications of local and district medical

societies on matters involving meetings and official activities of such societies.

Ohio State Society of Medical Assistants

Amendments adopted by the Ohio State Society of Medical Assistants and submitted to The Council for review and approval were approved by official action, with the exception of the proposed amendment to Chapter 5, Section 4, of the By-Laws of that organization.

The Executive Secretary was instructed to write to Dr. Gustafson on behalf of The Council, expressing regret that he could not attend the meeting and to hope that he would make a prompt convalescence from his disability.

The Council then adjourned to meet on February 21, 1959.

Attest: CHARLES S. NELSON,
Executive Secretary.

Industrial Health . . .

Business Transacted by Committee on November 16 Reported to and Approved by The Council; Two Subcommittees also Are Established

ACTIONS of the Committee on Industrial Health and Workmen's Compensation taken at a meeting of the committee held on November 16, 1958, were reported to The Council on December 13-14. The report, which was approved, summarized the following committee actions:

Reviewed the recent revisions in the Workmen's Compensation Medical Fee Schedule and decided that the increases were still inadequate and that it might be necessary for the Association to ask for additional increases in the not-too-distant future.

Gave consideration to the statement of policy on industrial medicine adopted by the Montgomery County Medical Society. Question was raised as to whether the statement of policy would prevent periodic examinations of employees and immunization services to protect employees against industrial hazards. It was suggested by the committee there should be a slight amendment to the county society's statement to make it perfectly clear that such services would not be deemed unethical.

Complaint Considered

Considered a communication questioning the propriety and the validity of certain statements made in a medical examiner's report of a Workmen's Compensation claim and recommended that the chairman discuss this matter with Mr. Young, Director of the Bureau of Workmen's Compensation; that Mr. Young be advised that it is the opinion of the committee that the language used in the report of the medical examiner was highly improper; that efforts should be made to have medical examiners avoid the use of language like that contained in this report; that Mr. Young

be asked to bring this matter to the attention of the medical examiner involved.

Asked Doctor Worstell and the Executive Secretary to follow up with Mr. Young on matters relating to revision of hospital contracts for the fiscal year starting July 1, 1959, to permit hospitals to include the cost of anesthetic materials in computations used to arrive at per diem costs, thus eliminating the provision that physicians would be expected to furnish the anesthetic material or reimburse the hospital for the same.

Subcommittees Decided Upon

Decided to divide into two subcommittees, one on Workmen's Compensation, and one on Industrial Health so both fields of activity can be adequately covered. Doctor Worstell stated that in all probability both committees would be brought together from time to time to pass on major matters coming before the various subcommittees but that the subcommittees could function independently with respect to many activities. He stated that he would continue as Chairman of the entire committee and would serve as Chairman of the Subcommittee on Workmen's Compensation. He appointed Doctor Rex Wilson to act as Chairman of the Subcommittee on Industrial Health; also designating Doctor Wilson to serve on the Subcommittee on Workmen's Compensation. The Executive Secretary was instructed to poll members of the committee to find out their preference for committee work and secure suggestions for basic activities of this subcommittee and recommendations of specific projects which can be carried on by the subcommittee.

Urged members of the committee to attend the Annual Congress on Industrial Health to be held in Cincinnati on the 16th, 17th and 18th of February, 1959.

Rural Health . . .

Report Made To Council on Scholarship, Preceptorships, Lectures To Students; AMA Has Been Invited To Hold Its 1962 Conference in Ohio

REPORT of the Committee on Rural Health presented to The Council on December 13-14 and approved by The Council covered a meeting of the committee held on September 24, 1958, in Columbus at which the following business was transacted:

Approved the report of the Scholarship Subcommittee concerning selection of Glenn Hisrich, Stone Creek, Ohio, Route 1, as recipient of the 1958 Ohio State Medical Association Rural Medical Scholarship.

Scholarship Evaluated

Voted to recommend to The Council that the scholarship be continued for another three or four years before any decision to change it is made. The committee noted that the scholarship has considerable public relations value among farm groups, that the rural groups look upon it as an indication the OSMA is interested in their problems, and that this relationship is important to OSMA. The committee instructed the secretary to get from the lay Scholarship Advisory Committee opinions on the scholarship.

Preceptorship Program

Previewed the 1958 preceptorship program. It was reported that all three Ohio medical schools will participate in the program during 1959.

Furnished dates and locations for the district conferences of the Ohio Rural Health Council to committee members for their information, and they were encouraged to attend the conference in their individual districts.

National Conference

Received report from Doctor Reiheld on the 1958 AMA Rural Health Conference, held at Jackson, Miss., at which he spoke on the preceptorship program being conducted by OSMA. It was noted that the conference will be held at Wichita, Kansas, in 1959, and in Michigan in 1960.

Instructed the secretary to determine what would be required of the committee and OSMA in bringing this conference to Ohio and voted to recommend to The Council that, if feasible, the AMA Council on Rural Health be invited to hold the 1962 AMA National Conference on Rural Health in Columbus.

The 4-H Health Programs

Reviewed its 4-H health programs. Forty-four subscriptions to *Today's Health* are being

given to 1958 county 4-H health contest winners; the winner of the boys' state health improvement contest will be sponsored at the National 4-H Congress in Chicago in December, and 80,000 4-H Personal Health Records have been distributed to club members.

Student Lectures

Decided that the 1959 lecture programs for senior medical students will be held at Ohio State, January 31, Cincinnati, February 8, and Western Reserve, March 21. The committee reviewed the lecture outlines and the chairman requested members to send to the secretary their suggestions for condensing the outlines. The committee also voted to appoint Mrs. V. R. Frederick, Urbana, Ohio, to the Scholarship Advisory Committee, and to invite Mrs. Frederick to speak at the lecture dinners.

Veterans Administration Sponsors Cleveland Clinical Sessions

The Veterans Administration is sponsoring a series of clinical conferences from 8:00 to 9:00 a. m. on Wednesdays in the Conference Room, 7th Floor, Cuyahoga Building, Cleveland. Dr. Charles Berns is chairman of the clinical conferences. Conference subjects and speakers scheduled in the near future are the following:

February 18—"Lower Extremity Disabilities—New Appraisal in Treatment"—Dr. Abraham W. Schenker.

February 25—"Virus"—Dr. Chas. F. Weiss, Dept. Clinical Investigation, Parke-Davis & Co.

March 4—"Gastro-Intestinal Bleeding"—Dr. Geo. L. Sackett.

March 11—"Significance of Aldosterone Activity and The Clinical Utility of the Aldosterone Antagonists"—Dr. Clarence L. Gantt, Division of Clinical Research, G. D. Searle & Co.

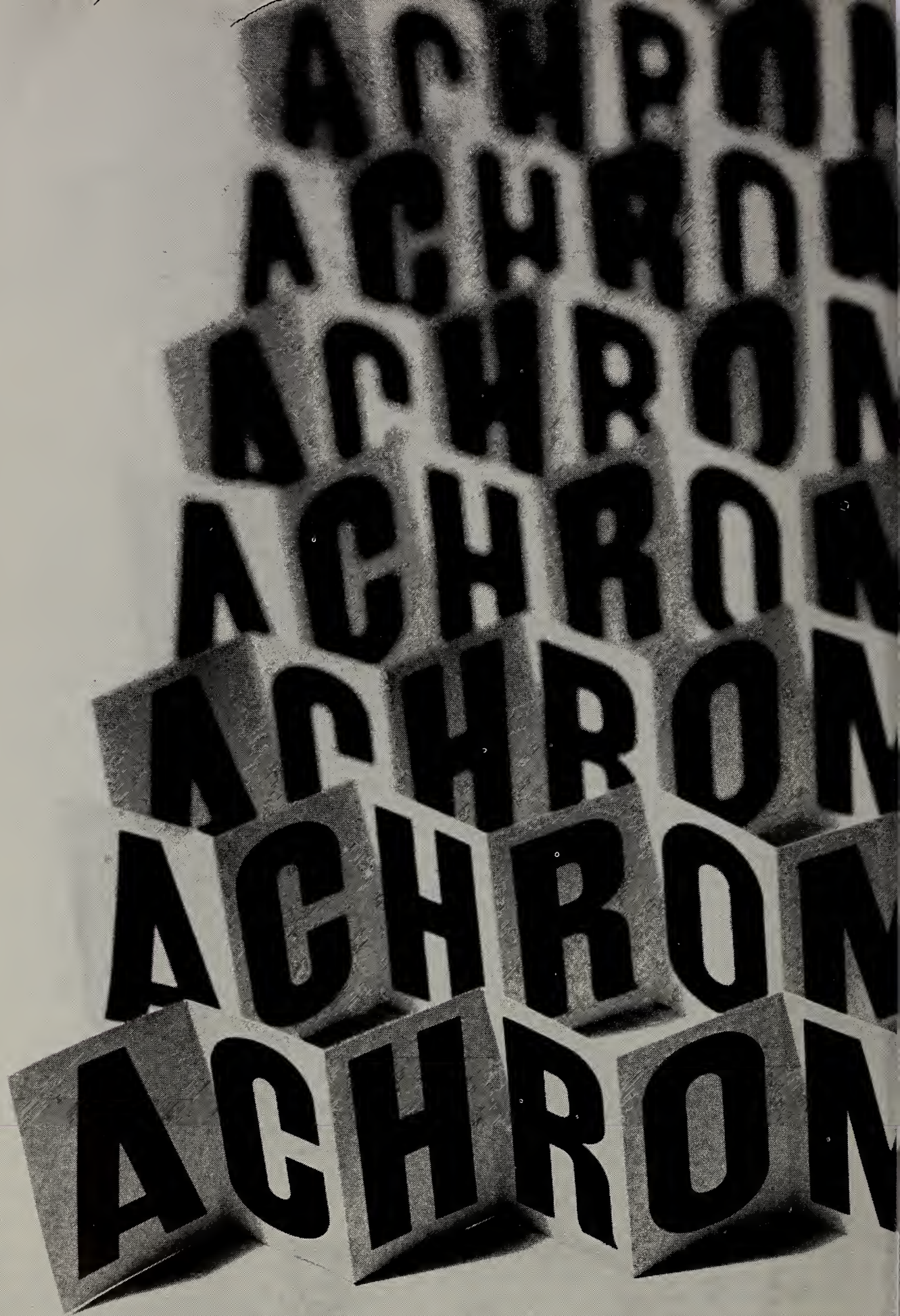
March 18—"Psychiatry and the Law"—Dr. F. J. Imburgia.

March 25—"Treatment of Cardiac Arrhythmias"—Dr. W. C. Gittinger, medical director, Chas. Pfizer Laboratories.

April 1—"Cerebral Vascular Insufficiency"—Dr. B. Berger.

April 8—"Some Interesting X-Ray Cases"—Dr. Robert Iseman.

April 15—"The Treatment of Backache—A New Approach"—Dr. A. W. Schenker.



All-Doctor Glee Club Will Entertain at Annual Meeting



Here are members of the Montgomery County Medical Society Glee Club with their director, Dr. W. J. Lewis, who will entertain at the Annual Banquet during the 1959 OSMA Annual Meeting, Columbus, April 21-24.

Forty-two members of the Montgomery County Medical Society comprise what is believed to be the only glee club in the country made up entirely of M.D.'s. This group will entertain doctors, their wives and guests at the Annual Banquet, Wednesday, April 22, during the 1959 OSMA Annual Meeting.

The Glee Club started in May, 1957, with a handful of interested people. It premiered in January, 1958, at the Montgomery County Medical Society inaugural. Since then membership has grown rapidly, as have requests for public appearances of the singing doctors.

The doctors sing everything from classical selections to pop tunes. A surprise bit of levity usually adds a gay finale to the evening's entertainment.

Here are the names of members of the Glee Club: Drs. W. J. Lewis, director; S. I. Adam, Joe Albrecht, F. G. Barr, L. O. Frederick, A. J. Carlson, J. L. Chesnut, R. M. Craig, D. E. Sando, G. H. Garrison, C. E. Gebhart, P. A. Granson, R. S. Graves, L. M. Haley, C. H. Hall, A. Hirsheimer, E. A. Millonig, E. E. Pinnell, A. B. Huffer, W. E. Johnson, H. E. Klaaren, J. H. Muehlstein, W. S. Koller, N. L. Kosater, R. P. Moon, C. E. Mumma, Ward McCally, W. L. McCowan, J. R. McWhirt, T. E. Newell, C. E. O'Brien, L. E. Palmer, F. F. Radcliff, S. J. Randall, H. D.

Robertson, R. G. Schmidt, A. D. Shafer, V. M. Shampton, J. Richard Strawsburg, J. F. Torrence and J. D. Welsh. Organist is Dr. L. O. Frederick.

Soloists include: Drs. Lewis, Albrecht, Hall, Randall, Chesnut, Pinnell and Muehlstein. Doctors in virtually all branches of practice are in the Glee Club. The director, Dr. Lewis, has been in musical activities since his high school days. In college he almost decided to make a career of show business.

General Practice Session Scheduled At Bunts Institute, Cleveland

The Frank E. Bunts Educational Institute affiliated with The Cleveland Clinic Foundation is offering the sixth annual day and one-half post-graduate course of particular interest to general practitioners. This course, open to all members of the medical profession, is sponsored by the Cleveland Chapter of the American Academy of General Practice February 11 and 12. The varied subjects to be presented are of general current interest. Due to limitation of auditorium capacity, registration will be limited to 150. Acceptances will be made in the order of receipt of applications.

The course will be held on the fourth floor of the North Clinic Building, located at Euclid Avenue and East 93rd Street.

Nobody Likes To Pay the Cost . . .

Whether It's Drugs, Medical Services or a Stay in the Hospital, the Consumer Is Likely To Lump It All Together as "Cost of Medical Care"

WHEN Fred Roll called me in July with an invitation to talk to this group of public relations experts on the costs of medical care, I had just finished a two and one-half hour discussion in my office with Charlie Brooks, a very sharp and able medical reporter.

His newspaper, the conservative and influential *Washington Star*, had assigned him to digging up the facts for a comprehensive series on the costs of medical care in the Nation's Capital. I presume the assignment stemmed from an uproar in the community over an announcement by Group Hospitalization, our counterpart of Blue Cross, that it was raising its rates as much as 40 per cent on some contracts.

The announcement produced demands on Capitol Hill for a Congressional investigation, and pressure from certain groups in the community, that the District of Columbia Commissioners "do something." When it was discovered that the government could do nothing about it because Group Hospitalization is a private, non-profit organization, there were threats of legislation to bring its operations under local government control.

When Brooks and I had our discussion, we started on drug prices, but we soon branched out into all phases of medical care costs. I suspect this happened for two reasons: First, because I believe that the problem of medical care costs must be approached in its entirety; and second, because my chief outside interest happens to be a hospital in Washington.

Closer Public Scrutiny

As I see it, we are heading into a period during which all elements in the costs of medical care will be subjected to closer public scrutiny than ever before. Today it may be drug prices, next week it might be Blue Cross or Blue Shield rates, and these could eventually lead into hospital charges and even medical fees.

In a sense, this is a reward for the dramatic achievements we have witnessed in the medical care field during the last decade. As a result of an unprecedented public interest in health and medical care, the people want the best, and the public is expecting even greater achievements in the future.

The press has educated the public on the bene-

Editorial Note:

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The above quotation is from an address entitled "Nobody Likes To Pay the Costs of Medical Care," given by Wallace Werble, editor and publisher of F-D-C Reports, Drug Research Reports, and other pharmaceutical reports, given before the 1958 AMA Public Relations Institute in Chicago, an abstract of which appears as the accompanying article.

In a series of articles, *The Ohio State Medical Journal*, is endeavoring to set forth the answers to some of the provocative questions being asked about the pharmacy industry, the costs of drugs, drug research, etc. This is the second in the series. The first article appeared last month.

The Journal believes physicians should have accurate information on these subjects so they will be able to answer the questions of their patients and, thus, dispel in many instances the misconceptions which people have about the costs of medical care, including the costs of pharmaceuticals.

fits of good medical care. People have been taught to expect more and more from doctors, from hospitals, from drugs, and from pre-payment medical care plans. When people are sick, they now want the best, though they frequently may object to paying the price.

In one way or another, every group supplying medical services or products will be called on to justify its charges or prices before some public forum—state or national legislative committees,

government bureaus, and national or local press media.

I have a hunch that the present system of supplying medical care, in the long run, will be judged by the public in its entirety. Whether they like it or not, all factors supplying medical care services and products may well find themselves in the same boat.

This could happen despite all efforts that may be made by individual groups to seal themselves off in criticism-proof compartments. I don't believe that any individual group can exclude itself from the medical care boat by pointing the finger of blame at another group.

All From Same Purse

So far as the public is concerned, it doesn't make too much difference whether the bill is tagged as professional fees, hospital rates, drug prices, or insurance premiums. The label means little to the consumer because the money must come from the same pocketbook or bank account. It all goes to paying the costs of medical care.

When it comes to paying the bills, I don't believe the public draws fine lines of distinction among professions, non-profit institutions, commercial enterprises, or insurance organizations. If anything, it probably has come to expect more for free from the professions and the non-profit institutions. I am afraid that more eyebrows are raised at the doctor who drives a Cadillac than at the pharmaceutical company which makes a profit, though both are equally justifiable under our system which has provided the best medical care for the most people.

Of course, this public scrutiny will not be directed at the entire field of medical care at any one time. It will be done piece-by-piece or segment-by-segment, and the specific object of scrutiny will vary from time-to-time, place-to-place, and forum-to-forum. Regardless of which segment may be under fire at the moment, there is always the chance that the flames will spread to engulf the whole field.

"Uncle Sam, Please Pay"

For example, let me tell you what happened on the Senate floor last August 15 and 16 during the debate on a proposal to boost the House-approved increase in social security payments from seven to ten per cent. Sen. Yarborough, a Democrat from Texas, who sponsored the unsuccessful 10 per cent proposal, told the Senate that, "because their medical costs increase," people on social security cannot afford much more than beans and potatoes. I ask you to note the transition from the general phrase "medical costs" to the specific word "medi-

cine" as the Senator from Texas continued his argument in the following words:

"Medicines which one could buy 25 years ago for perhaps 75 cents at the local drugstore, on a prescription, now cost \$2 or \$3, and sometimes even \$4 or \$5. . . .

"I have had the owners of small drugstores in the towns of my state tell me, with tears in their eyes, that old people come into drugstores and ask for credit in order to buy some drugs. . . . Medicine is one item we ought to consider as one reason for higher payments."

Bargain Price for "the Best"

Naturally, Senator Yarborough did not compare the therapeutic values of the drugs available 25 years ago and those in use today. Very likely, the 75 cent prescription belonged to the "punt, pass, and prayer" era of therapeutics. Later, Senator Magnuson, Democrat of Washington, joined the debate. Note how easily Senator Magnuson makes the transition from "medical care" to "drug prices" in the following declaration to the Senate:

"When I came into the Chamber, the junior Senator from Texas was mentioning the small fixed incomes which elderly people have. In addition, usually, elderly persons need more medical care than others, and much of their income goes to pay for drugs and other medical care.

"The junior Senator from Texas gave very valuable help to the Committee on Interstate Commerce when, about a year ago, we directed the Federal Trade Commission to look into the exorbitant prices being charged persons in this category and the cost to them of new drugs which are so vital. The results of that investigation came out last week, and they proved we were correct in our premise that the prices charged were exorbitant, and that the cost of medical care could eat up a large percentage of the income of these people. . . ."

Personally, I can't see too great a gap between using medicine and medical costs as an argument for a further increase in social security payments, and using the need for supplying medical care to old people as an argument for the Forand bill. The latter, as you know, would have supplied surgical services and hospital care to social security beneficiaries, and was vigorously opposed by the American Medical Association and other groups on the grounds that it would be a first step toward a system of national health insurance.

Basically, PR Is Favorable

Unfortunately, I come before you without any expensive surveys or opinion polls to prove this point, but I have the feeling that, by and large,

the individuals and groups engaged in supplying medical services and products operate in a favorable public relations climate.

I know that you often hear lay people criticize doctors, but taking a broad view, physicians are always among the most respected men or women in their communities. On the national scene, I cannot recall when Congress enacted major legislation that was strongly opposed by the American Medical Association.

Hospitals appear to me to enjoy an almost charmed public relations status in their communities. The enrollment in Blue Cross and Blue Shield prepayment plans attest to their popularity.

Wonder Drug—Wonderful Story

The pharmaceutical industry has benefited from an almost steady stream of "wonder drug" stories in the nation's consumer publications. Once in awhile there may be a backfire, but on the whole the industry's dramatic research story has been effectively told in terms of products that have meaning to the consumer.

All things considered, the industry came through the initial phases of government action against antibiotic and polio vaccine manufacturers better than might have been anticipated. The daily press handled both actions as one-day stories which included the denials as well as the charges. The pharmaceutical companies answered the government allegations in both instances promptly, vigorously, and effectively from their own points of view.

A Unique Status

Despite the good natured bantering about sandwiches and hardware, the pharmacist has a unique status of his own in the community—a status which could provide a satisfying existence if he didn't suffer from an inferiority complex that makes him feel he is the low man on the medical totem pole.

If the PR picture is so favorable, then why are we here? As I see it, there is one fundamental public relations problem that has not yet been successfully approached, and I often wonder whether it ever will be adequately handled. Here is the problem as it appears to me:

The public generally has a high regard for everybody who supplies medical services and products. It is using these services and products in increasing quantities, and it is demanding more and more. The problem arises from the fact that people just don't like to pay the costs of medical care.

Most people do not like to be sick, and for this

reason instinctively rebel against paying the costs associated in their minds with sickness.

People Don't Like To Be Sick

Since they did not want to be sick in the first place, they regard expenditures for getting well as "money down the drain"—something like taxes. They would rather have spent the money on food, clothes, housing, automobiles, furniture, vacations, TV sets, liquor, or anything else that would satisfy a desire or fill what they regard as a need.

Of course, there are exceptions—a few people don't mind being sick; others become philosophical about it; and finally there is the occasional grateful patient whose life was saved under dramatic circumstances. There are even instances when gratitude evaporates after the bill is rendered.

Conversation Topic

In one way or another, everybody complains about the costs of medical care. It is a popular topic of social conversation. I have heard the socially prominent, politically-conservative wife of a doctor spend the better part of an evening violently denouncing the fees charged by her dentist.

All of you have heard people talk about how much their operations cost, or how much they had to pay for a prescription. In group conversation, this kind of talk almost approaches a form of "bragging," and is frequently used as a means of establishing a social status. The first person to bring the subject up just doesn't have a chance. He is inevitably topped as the conversation goes around the room.

Even among those engaged in supplying the various elements of medical care, there is the feeling that the "other fellow" is charging too much. The doctor thinks that drugs cost too much; the pharmacist blames the manufacturer; the hospital administrator, faced with a deficit, would like to get a larger percentage of the fees collected for the anesthetist or pathologist; the medical man thinks the surgeon gets all the gravy; the Blue Cross administrator thinks hospital costs are too high; and so on.

Not Only the Poor Complain

This critical attitude cuts across all population groups. It is not limited to poor people, to radicals, to political liberals, to trade union leaders, to Democrats, or even to government officials.

The House subcommittee that investigated the prices paid by the government for polio vaccine was controlled by the Democrats, but it was a Republican attorney general—a close political and

personal friend of Vice-President Nixon—who authorized the antitrust proceedings against the producers.

The Federal Trade Commission's antibiotic investigation, which resulted in a report and a legal complaint attacking the pharmaceutical patent and pricing systems, was originally kicked off, I am told, five years ago by a conservative, silk-stocking Republican who was then chairman of this agency.

At the time, he had just paid for some antibiotics for a sick member of his family, and he thought the price was too high. So he got the Commission to authorize an inquiry that later blossomed into a full-blown investigation.

Some people are more vocal than others in expressing their resentment against the costs of medical care. And some are willing to try to convert this resentment into a political issue which they hope will insure their election or re-election.

Being only an editor, and not a psychiatrist or psychologist, I just don't know how to tackle this fundamental PR problem. If my view on the basic public attitude is correct, I doubt whether there is any way to convince the consumer that medical care is cheap.

And if it were possible to convince the consumer of this, I am not sure it would be a good thing. After all, medical care is precious because it involves life and health, and I am not certain anything would be gained by trying to cheapen its value.

Also, good medical care is not cheap; it costs money, and somebody has to foot the bill, in one way or another. Maybe we have made a mistake in failing to confront the lay public with this hard fact.

I don't think comparative statistics will do the job. If so, you wouldn't be faced with the problem now. The Bureau of Labor Statistics' cost-of-living index, released last Friday, shows that the cost of medical care has almost doubled since 1939, but the percentage increase is less than for every other major element in the cost of living, except housing.

The entire index has gone up 108.6 per cent since 1939, and the cost of personal care has risen 116.3 per cent. Figures like this are good to have, but they don't convince anybody—even you.

From the standpoint of the problem we are talking about, the following paragraph from the Bureau's explanation of the increases between June and July of this year is much more important than all the statistics in its learned table. Under the heading of medical care, the Bureau said:

"The medical care index was up 0.5 per cent,

primarily because of substantial increases in rates for group hospitalization insurance in Minneapolis, Philadelphia, and Pittsburgh. Hospital room rates and fees for dentists' and physicians' services also advanced. Prices of prescriptions and drugs declined slightly."

Is there a doctor in the audience? If so, I'll bet you don't believe that last sentence about the prices of prescriptions and drugs declining. In case anyone would like to see it with his own eyes, I brought along an official copy of the Bureau's statement.

The short paragraph from the Bureau of Labor Statistics report brings me back to just about where I started—to my point that all elements in the cost of medical care are facing increased scrutiny from the public, and that all suppliers of medical services and products are in the same boat.

If you can't do anything to stop this public interest and scrutiny, then what can you do? Here are a few suggestions from a well-meaning editor, but you must remember that I sit on the other side of the table from you:

What You Can Do

First, relax! If scrutiny is inevitable, make the best of it. Continue to tell your stories, each in his own way. Increase the effectiveness of your approach by finding some way to put the "public" into your public relations. When you tell your story, emphasize why your position is good for the consumer—not good for you, but good for the public. If you can't find a sound argument from this standpoint, then re-examine your position.

Second, prepare to justify your charges and prices in terms of the public interest. Don't waste your time in damning the people who ask the questions; if they didn't ask them, somebody else might. Once the question is raised, tell the people why they have to pay for good medical care. Tell them that somebody has to pay for it. If you have prepared your justification, and nobody asks for it, you can consider yourself lucky in two ways—the second way being the fact that you had to think the problem through for your own benefit.

Third, take a good, hard, cold look at your own position—at the way you would answer the questions most likely to come up. Ask yourself in private candor—how will this look in the afternoon newspaper? If you think you have some skeletons in the closet, try to figure out some way to get rid of them. You won't be able to keep them hidden forever.

And finally, defend the entire system of medical care—not just the segment in which you play a part. It is a good system; if you don't believe it

is the best one for the public as well as for you, and if you don't feel you can defend it with real conviction on that basis, find another job or another profession. If you don't know enough about the entire system to defend the other segments, at least don't try to get out from under by pointing

an accusing finger at somebody who is in the same boat with you.

Actually, all of us interested in the medical care field are in the same boat—even pharmaceutical editors and hospital board members. If nothing else, an editor is a consumer of medical care.

Traffic Safety . . .

Special Handbook on Medical and Physical Aspects of Safety Will Be Sent by OSMA Committee to Local Committees, The Council Is Advised

A SPECIAL HANDBOOK on how to set up a traffic safety program is being prepared by the Committee on Traffic Safety of the Ohio State Medical Association. This was reported to The Council on December 13-14.

The handbook will suggest many activities in which local committees can engage, such activities to emphasize the medical and physical aspects of traffic safety.

The report of the committee which was approved by The Council stated that the committee had taken the following actions at its last meeting:

To Present Exhibit

Accepted the invitation of the Committee on Scientific Work to sponsor an exhibit at the 1959 Annual Meeting, April 21-24, Columbus.

Decided to establish more liaison with traffic safety agencies on a State level at a later date.

Voted to continue active cooperation in the Cornell Medical College of Surgeons Study in Ohio.

Requested the Executive Secretary to see that the activities of the committee are properly publicized in *The Journal* and in other publications to members.

Emergency Room Standards

Decided that at a later date, efforts should be made to establish and promote minimum standards for emergency room care in hospitals and in physicians' offices. The committee was advised that the Ohio Trauma Committee, American College of Surgeons, has already started such a study. The cooperation of the Traffic Safety Committee was voted. A letter is to be sent to county society committees asking them to encourage physicians to cooperate in the study; a similar letter to go to the Ohio Hospital Association.

Voted to cooperate with the Ohio Chapter, American College of Surgeons, on postgraduate courses for physicians in the prevention, evaluation and treatment of traffic injuries.

Decided at a later date to review the physical requirements contained in the driver license law and to point out necessary changes, if any, to the proper officials or the Legislature.

Physical Exams

Decided to investigate, at a later date, the possibility of required physical examinations for repeated traffic offenders in an effort to determine why they are accident-prone.

Decided to encourage interested officials and agencies to consider the feasibility of requiring visual examinations of drivers at stated intervals.

Voted to recommend to The Council that the Association support properly drawn legislation providing for chemical tests to determine drunken driving.

Decided to check at a later date on the existing physical standards required of bus drivers, both school bus and commercial. It was thought that contact should be made on this with the State Board of Education and with the State Utilities Commission. At the same conference there should be discussion of the driver education programs and driver classes for high-school students for the purpose of emphasizing to the students the medical aspects of safe driving.

Possible Legislation

Suggested that there be an educational program among physicians urging them to observe safe driving habits and traffic laws; and to impress on them the fact that when they have the word "Physician" on their license plates, this privilege carries with it equal responsibility.

Decided to consider legislation for compulsory inspection of motor vehicles, after an opportunity is offered to analyze any such bill.

Received reports from Doctor Davies and Doctor Weckesser on the Traffic Safety Conference held in Columbus several months ago under the sponsorship of the Governor.



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*A Symposium on the Pharmacologic Effects of Dartal on the Liver, Chicago, Searle Research Laboratories, Feb. 7, 1958.

Laboratory Services . . .

Ways and Means of Improving Them in Ohio Discussed by Special Committee; Future Activities Decided Upon at Meeting, December 7

AT A MEETING of The Council on December 13-14, a report of the new Committee on Laboratory Medicine was considered and approved. Members of the committee are: Dr. H. B. Davidson, Columbus, chairman, Dr. Edward L. Burns, Toledo, Dr. John B. Hazard, Cleveland, Dr. Melvin Oosting, Dayton, Dr. Arthur E. Rappoport, Youngstown, Dr. William B. Smith, Zanesville, and Dr. Philip B. Wasserman, Cincinnati.

The report was based on a meeting of the committee held in December, 1958, when the committee voted to proceed as follows:

Conference at Annual Meeting

1. Sponsor a conference on Laboratory Medicine on Thursday morning, April 23, during the 1959 Annual Meeting of the OSMA, to be held in Columbus April 21-24. The subjects to be presented are: laboratory quality control; and recruitment and education of medical technologists. It was voted to request The Council of OSMA to authorize the payment of an honorarium and expenses for one out-of-state guest speaker for this session.

2. Request a joint meeting in Columbus of the Committee on Laboratory Medicine with the Committee on Professional Relations of the Ohio Hospital Association to discuss the following projects contemplated by the committee:

(a) A survey of hospitals and pathologists to ascertain which hospitals have pathologists supervising their laboratories and whether they are full-time or part-time. Ohio pathologists will be polled as to their availability to provide consultation service for smaller hospitals. It was suggested that this survey of hospitals should include a request for the name of the Chief of Staff.

(b) Contact hospital administrators to emphasize the desirability and importance of having at least one ASCP trained technologist in each hospital laboratory.

(c) Encourage the recruitment of medical technologists by hospital administrators.

(d) Provision for weekly or other periodic seminars of laboratories in Ohio hospitals.

(e) Post-graduate training in special fields, such as bacteriology.

Refresher Courses for Technologists

3. Develop regional post-graduate refresher courses for medical technologists. It was agreed that members of the committee would bring to the next meeting a list of topics to be covered in such refresher courses.

4. Have State Headquarters staff contact representatives of the Ohio College Association and public and private agencies concerned with vocational guidance to stimulate their interest and obtain support for the committee's recruitment program.

5. Offer consultation service to laboratories requesting it, by members of the committee and possibly other pathologists, on a voluntary basis.

Self-Evaluation Program

6. Encourage participation in the self-evaluation service now provided by the College of American Pathologists, American Society of Clinical Pathologists, American Association of Blood Banks, and F. W. Sunderman, M. D., Philadelphia, Pa.

7. Publish once a year in *The Ohio State Medical Journal* a list of Ohio clinical laboratories which are participating in any one of the above-mentioned self-evaluation tests.

8. Accept, for the present, the Directory of Pathologists for Specialized Laboratory Procedures, published by the College of American Pathologists, as a source of referral for the more difficult or less frequently performed types of tests not ordinarily available in smaller laboratories.

Sprayed BCG a Possibility

The possibility that use of BCG vaccine in spray form may make it possible to immunize large numbers of persons simultaneously has been raised by animal experiments at the National Jewish Hospital and the University of Colorado School of Medicine here.

Drs. M. L. Cohn, C. L. Davis and Guy Middlebrook found that airborne BCG, in quantities much smaller than required for injection, protected guinea pigs against subsequent challenge with fully virulent tubercle bacilli.

Poison Control . . .

Activities of Committee Reported To and Approved By The Council; Idea of Establishing Single Central Center for the Entire State Vetoe

ACTIVITIES being undertaken by the Committee on Poison Control of the Ohio State Medical Association were reviewed in a report presented to and approved by The Council of the Association on December 13-14.

The report of the committee covered a meeting held on September 24 when Bernard E. Conley, Ph. D., Secretary, AMA Committee on Toxicology, was present. Dr. Conley discussed before the committee, poison control centers and their problems and the AMA's proposed uniform labeling law. Dr. Conley told the committee that there are about 150 poison control centers in the United States, operated largely on a voluntary basis, in a professional spirit. He said that nine states have networks which preserve activities of local centers which make their reports to central agencies in each state. Arizona, California, Connecticut, Florida, Illinois, Massachusetts, New York, Oklahoma and Texas have such networks.

Special Article

The committee took the following actions:

Voted to approve for publication an article entitled, "Poison Control, Statewide Program," written by Chairman Norman, for publication in *The Journal*. (See November, 1958, issue.)

Agreed to the listing for the time being of centers located in Akron, Cincinnati, Cleveland, Columbus, Springfield and Toledo.

Decided that any additions to the list of poison information centers published in *The Ohio State Medical Journal*, under the sponsorship of the committee, should be subject to the approval of the Committee on Poison Control.

Single Center Not Feasible

Voted to adopt the following recommendation to The Council, for reference to the House of Delegates of the Ohio State Medical Association, in regard to Substitute Resolution No. 13, adopted by the OSMA House of Delegates at the Annual Meeting of the Ohio State Medical Association April 17, 1958, and advocating plans for a single central poison control center:

The committee after studying various methods of effectuating this recommendation does not consider feasible the establishment of a single central poison information center in Ohio at this time.

The committee has investigated a number of

suggestions for the establishment of such a center, including: administration by the OSMA; administration by the OSMA and other voluntary associations; administration by a state agency; the extension of one of the existing centers.

It was determined that financing and facilities were not available to establish an acceptable central center.

To Cooperate With Local Centers

In lieu of a single master center, therefore, the committee suggests that existing centers be strengthened, encouraged and utilized and made more readily accessible to physicians in rural areas; that existing centers might, for the time being, obtain poison information from the National Clearing House in Washington, D. C., when necessary.

The proposed uniform labeling act drafted by the American Medical Association was discussed and the committee decided to continue studies of the possibility of supporting such legislation in the Ohio General Assembly.

Conference With Others

The committee reported that it held a dinner meeting with representatives of the Ohio Department of Health and Ohio State Pharmaceutical Association, at which the ways in which physicians and pharmacists could work together in solving poison control problems were discussed.

Fluoroscopes Found Unsafe

Only one fluoroscope of 81 surveyed in the Philadelphia area met the maximum safety criteria set by the National Committee on Radiation Protection, according to a study reported here by Robert O. Gorson of the University of Pennsylvania Hospital and Jesse Lieberman of the Philadelphia Department of Public Health.

In the study, jointly sponsored by the University and the Health Department, three basic criteria were used for evaluating the fluoroscopes: exposure dose rate, half-value layer and scattered radiation levels. Only 12 of the machines passed muster with regard to these primary standards.

Surgeon General Leroy E. Burney USPHS has warned the nation there is a rising tide of medical evidence that air pollution is a causative factor in cancer and other major diseases.

Care of the Aged . . .

Activities of Association's Committee Reviewed; To Support Adequate Appropriations for State Division's Program on Medical-Health Care

A REPORT on its activities during recent months was presented to The Council on December 14 by the Committee on Care of the Aged. By official action The Council approved the committee's activities and urged it to expedite in every possible way its efforts to come up with feasible recommendations for solving some of the medical and health problems confronting aged citizens of Ohio.

The report told of a conference held on November 19 by the committee with officials of the State Welfare Department and of the Division of Aid for the Aged for the purpose of discussing the financial situation confronting the Division, especially with regard to the Health Care Program.

Funds For Medical Program

It was agreed at the conference that efforts should be made to have the State Legislature make an appropriation adequate to permit:

A return to the medical fee schedule in effect from July 1, 1956 to June 30, 1957;

Continuance of certain controls on payments for visits as now in effect—a maximum of two calls for chronic cases; a maximum of ten calls for acute cases;

Elimination of provision for prior authorization for elective surgery;

Restoration of mileage to 50¢ per mile one way.

Members of the OSMA committee advised that members of the Association would be solicited to confer with legislators on this matter and urge the necessary appropriations. Also, it was agreed that OSMA representatives would contact the legislative leaders, as well as the new state administration, urging restoration of the health care program to its 1956 level.

Nursing Homes Licensing Proposal

Conferences held with representatives of the Ohio Association of Nursing Homes were summarized in the committee report.

A proposal to establish a new, and improved, system for the evaluation and licensing of rest homes, nursing homes, rehabilitation and convalescent homes, and homes for those with chronic illnesses was discussed. The nursing homes asso-

ciation anticipates sponsoring such a bill in the 1959 session of the State Legislature.

The OSMA committee voted support of such a bill, in principle, and so reported to The Council, which concurred. Further action by the OSMA should depend on evaluation of the bill introduced and specific action after such evaluation, the committee reported to The Council.

Chronic Disease Beds

The matter of conversion of parts of local or district tuberculosis hospitals into facilities for the care of patients with other diseases was discussed by the committee. No immediate action was recommended, pending careful study of any proposal on this subject which might be presented to the State Legislature. The committee agreed that it would be happy to serve in an advisory capacity to institutions planning to establish facilities for the care of persons with chronic illnesses at this time, or in event a bill like the one referred to above is enacted.


Voluntary Insurance For Aged

At the committee conferences there was a discussion of the question of providing more adequate and extensive coverage for aged retired persons through voluntary health insurance. It was pointed out that a resolution on this had been submitted to the American Medical Association by the Ohio delegation and had been favorably accepted by the AMA. Steps are being taken to bring this about, the committee was advised. The committee is planning conferences on this subject with representatives of voluntary medical and hospital groups.

Fort Steuben Academy

The Fort Steuben Academy of Medicine met for dinner on January 13 at the Fort Steuben Hotel, Steubenville. Speakers were Dr. R. B. Turnbull, surgical staff, Cleveland Clinic, and Dr. John Liggett, surgical staff, Sewickley General Hospital, Sewickley, Pa. The topic was "Constipated Children."

More than 3,500 surgeons, nurses, and related medical personnel from throughout the country are expected to attend a comprehensive, four-day Sectional Meeting of the American College of Surgeons in St. Louis, March 9 through 12, 1959.



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¹. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933



LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Proposed Amendments of OSSMA . . .

Medical Assistants Society House of Delegates To Vote on Suggested Changes in Its Constitution and By-Laws in Meeting Scheduled May 1

THE following proposed amendments to the Constitution and By-Laws of the Ohio State Society of Medical Assistants, suggested by the Constitution and By-Laws Committee of that organization, have been approved by the Advisory Committee of the Ohio State Medical Association, and are being published in *The Ohio State Medical Journal* as required by the Constitution of the Ohio State Society of Medical Assistants, so that they can be submitted to the House of Delegates of the organization on May 1, 1959.

Proposed Amendment No. 1

The amendment proposes the insertion of "the immediate Past-President" in the list of officers of the society in Article 8 of the Constitution. As amended the article would read: "The officers of this society shall be a President, a President-elect, the immediate Past-President, a Secretary and a Treasurer, all of whom must be local members or members-at-large of this society."

Proposed Amendment No. 2

Amendment No. 2 proposes that the fiscal year, for the purposes of membership, be changed to begin on January 1 and end on December 31 instead of beginning June 1 and ending May 31 as provided under the present Constitution, to coincide with the fiscal year of the American Association of Medical Assistants. As amended, Article II would read: "For the purpose of membership, the fiscal year of this society shall begin on January 1 and end on December 31 to coincide with the fiscal year of the American Association of Medical Assistants."

Proposed Amendment No. 3

Amendment No. 3 proposes changes in Sections 5 and 6 of Chapter 1 of the By-Laws regarding membership. In Section 5 the following sentence is added for the implementation and clarification of election of honorary members in the Ohio State Society of Medical Assistants. "Nominations made by the Board of Directors for honorary membership shall be voted on at any regular meeting of the House of Delegates and if approved by a majority vote of the Delegates present and voting, the nominees shall become honorary members of this society." This sentence would immediately follow the first sentence in Section 5 of the present Constitution.

In Section 6, the present By-Laws provide that application for membership-at-large and associate membership must be voted on at a regular meeting of the House of Delegates after review by both the Membership Committee and the Board of Directors. Because of possible unnecessary delay in electing these applicants to membership, and because of adding detailed work on the House of Delegates which is primarily a policy-making body, it is recommended that this procedure be simplified by giving the Board of Directors authority to elect these two classes of applicants to membership without submitting their names for action by the House of Delegates. These sections, if amended, would read as follows:

"Section 5: Nominations for honorary membership may be made by the Board of Directors by an unanimous vote of the Board. Nominations made by the Board of Directors for honorary membership shall be voted on at any regular meeting of the House of Delegates and if approved by majority vote of the delegates present and voting, the nominees shall become honorary members of this society. Not more than two persons shall be elected to honorary membership during any one year."

"Section 6. Applications for membership-at-large and associate membership after review by the Membership Committee shall be considered by the Board of Directors and if approved by majority vote the applicant shall, upon payment of dues, become a member of the Ohio State Society of Medical Assistants."

Proposed Amendment No. 4

Amendment No. 4 proposes changes in Sections 1, 2 and 4 of Chapter 2 of the By-Laws regarding dues and assessments.

Section 1, as amended, would eliminate the necessity of amending the By-Laws whenever the House of Delegates in annual meeting votes a change in the annual dues. Section 2 changes the date dues become payable so as to coincide with the proposed change in the date of the fiscal year under Article 11 of the Constitution. Section 3 changes the delinquency date for dues under the proposed change in the date of the fiscal year.

Paragraphs 1 and 2 in Section 1 would be deleted, and in their place the following substituted: "The annual dues shall be determined by

Conference for County Society Officers and Certain Local Chairmen, Sunday, February 22, Columbus

ANUAL CONFERENCE for officers and certain committee chairmen of County Medical Societies—an invitational meeting sponsored by the Ohio State Medical Association—will be held on **Sunday, February 22, at the Deshler-Hilton Hotel, Columbus.** Invitations are being sent to those for whom the meeting has been planned.

"How To" roundtables will be held for County Society presidents and secretaries; for chairmen of Public Relations Committees; and for chairmen of Legislative Committees. OSMA officers, Councilors and committeemen in these areas will participate in the roundtables at which suggestions on ways of getting the jobs done will be tossed around.

Out-of-state guest speakers will be Dr. Julian P. Price, Florence, S. C., vice-chairman of the Board of Trustees, American Medical Association, who will review the medical-health situation in Washington, and Mr. Leo Brown, director of public relations for the AMA, who will talk about the 1959 AMA public relations program.

Other program features will include a discussion on how medical societies may avoid legal pitfalls by Mr. Wayne E. Stichter, legal counsel, OSMA, and a review of good and bad bills before the Ohio General Assembly by Mr. George H. Saville, director of public relations and assistant executive secretary, OSMA.

The conference will start at 9:00 A. M. and run to 4:30 P. M. with a complimentary luncheon at about 12:30 P. M.

the House of Delegates at the annual meeting and shall be levied per capita on the membership. The annual dues of this society shall not exceed fifteen dollars per active member, which shall include the annual dues to the American Association of Medical Assistants."

"Special assessments for unusual or extraordinary activities or expenses of this society may be voted and levied against dues-paying members by the House of Delegates by three-fourths vote of the Delegates present and voting."

Paragraph 1 of Section 2 would be amended to read: "Dues shall be payable to the Treasurer of this Society on or before January 1 each year, except in the case of new members whose dues are payable at the time of application for membership."

Section 4 as amended would read: "Members whose dues have not been received by the Treasurer of this society on or before March 1 of each year shall be dropped from the membership roster of this society."

Proposed Amendment No. 5

Paragraph 1 of Section 2, Chapter 3 on House of Delegates and nomination and election of officers as amended would read as follows: "Each component society shall be entitled to one Delegate for each twenty-five members of this society, or fraction thereof, provided, however that each component society shall be entitled to at least one delegate. Delegates from each component society must be certified to the Secretary of the Ohio State

Society of Medical Assistants by the Secretary of the component society at least ninety days prior to the annual meeting."

Section 5, Chapter 3 of the By-Laws as amended for clarification would read: "No officer or director shall hold the same office for consecutive terms."

Proposed Amendment No. 6

In line with the proposed Amendment No. 3 regarding manner of election of members-at-large and associate members, a change is proposed in the wording of Paragraph C, Section 3, Chapter 4 of the By-Laws on duties of officers and directors.

Paragraph C, Section 3, Chapter 4 as amended would read: "Review applications for membership-at-large and associate membership submitted by the Committee on Membership as provided in Chapter 1, Section 6."

The Division of Obstetrics and Gynecology of the International College of Surgeons has announced its second annual competition on manuscripts in the field of obstetrics and gynecology. Details may be obtained from Dr. Harvey A. Gollin, secretary of the prize committee, 55 East Washington St., Chicago 2, Ill. Deadline is June 1.

The American Medical Association's Chemical Laboratory has announced plans to develop a coding system to aid in the identification of drugs by noting their physical characteristics.

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Controls Inflammation and Swelling...Relieves Pain...
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References: 1. Innerfield, I.; Shub, H., and Boyd, L. J.: New England J. Med. 258: 1069 (May 24) 1958. 2. Miller, J. M.; Godfrey, G. C.; Ginsberg, M. J., and Papastrat, C. J.: J. A. M. A. 166:478 (Feb. 1) 1958. 3. Davidson, E.; Prigot, A., and Maynard, A. de L.: Harlem Hosp. Bull. 11: 1 (June) 1958 *Reg. U. S. Pat. Off.

In Sinusitis

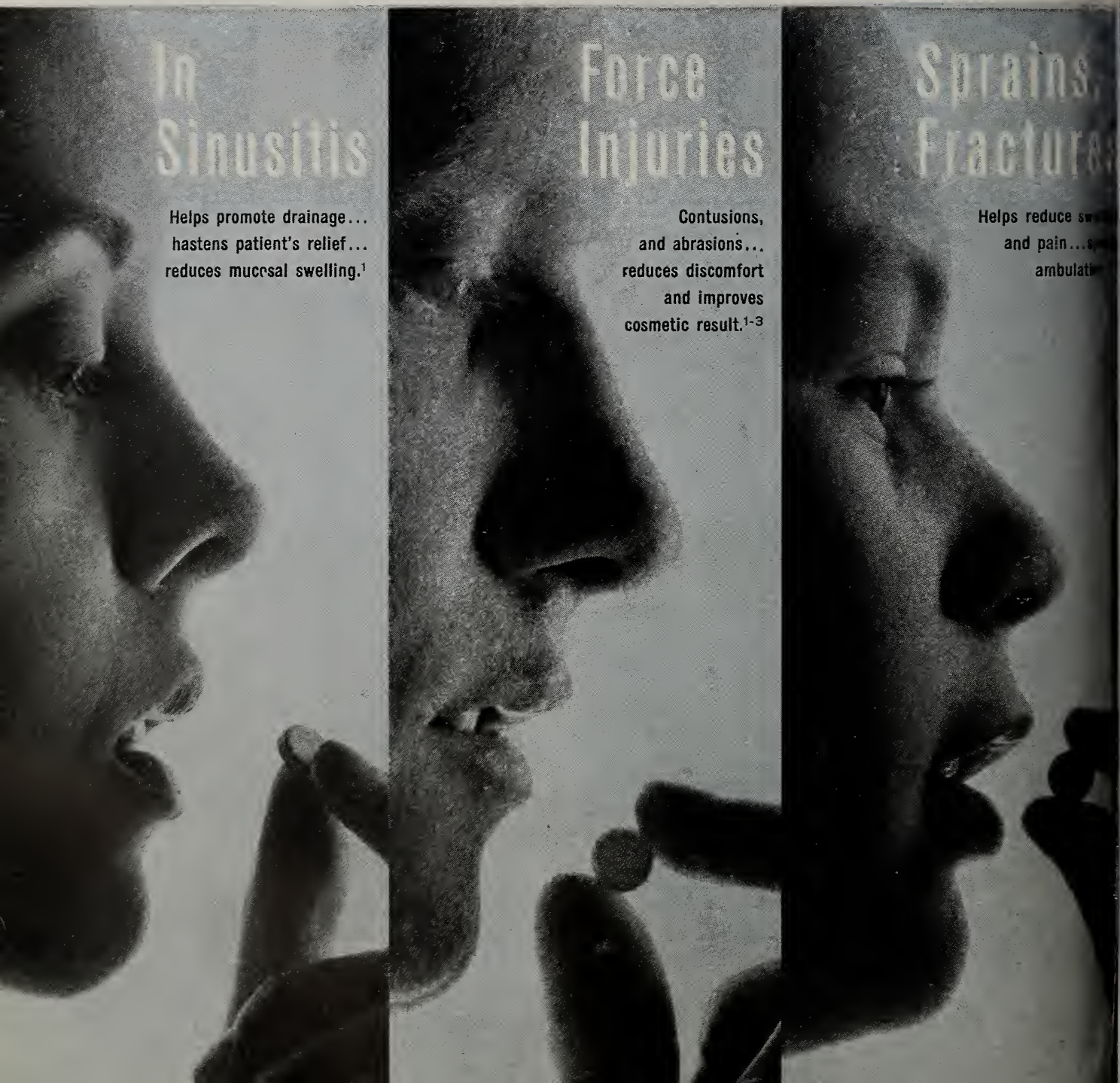
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and improves
cosmetic result.¹⁻³

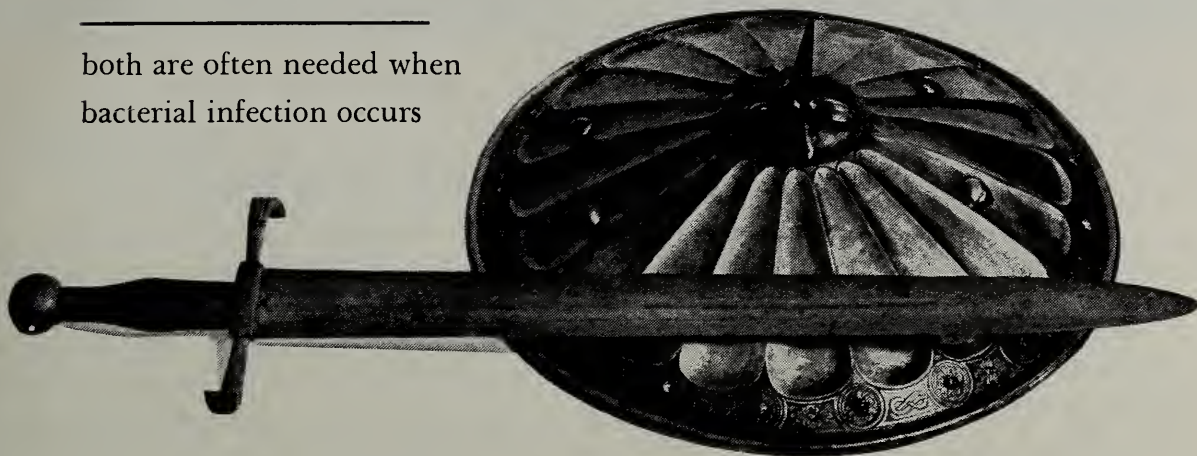
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monilial complications

both are often needed when
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SIMPLIFIED INSURANCE CLAIM FORM NOW AVAILABLE TO MEMBERS OF OSMA; HERE ARE INSTRUCTIONS ON HOW TO GET A SUPPLY FOR YOUR USE

THE OHIO STATE MEDICAL ASSOCIATION has developed a simplified insurance claim form designed to facilitate the furnishing of information by physicians to insurance companies in connection with health and accident claims.

The proof of claim form, recommended by the Committee on Public Relations and Economics of the OSMA after many months of study, has been approved by The Council. The format is a composite of similar forms which have been used successfully by a number of local academies of medicine, including Cincinnati, Cleveland and Toledo.

It is believed that all essential information for use in health and accident claims can be furnished on this form. No provision is made on the form for listing charges. It was the feeling of the committee that in those cases where this information is necessary for the settlement of a claim, the request should come through the policyholder.

While there is no guarantee that all insurance companies will accept the OSMA-approved form, it is the hope of the Association that this simplified, standardized form will eventually be accepted by all insurance companies in lieu of their own forms.

The simplified form should **NOT** be substituted for claim forms prescribed by law, e. g., claim forms of the Ohio Bureau of Workmen's Compensation and other government agencies. Also, it should **NOT** be used in place of the claim form used by Ohio Medical Indemnity, Inc., (Blue Shield), which requires less information than the OSMA-approved form.

The new form is printed in pads of 50 duplicate sets, the original in white to be fastened to the insurance company's form and the duplicate in yellow to be retained in the physician's file.

Arrangements have been made with the Ohio Printing Company, Ltd., 32-34 W. Noble St., Columbus 15, Ohio, to print and distribute the form. **Members should place orders direct with that company.** To minimize the amount of billing and bookkeeping, cash or a check must accompany each order.

The price of a pad of 50 sets of the form, in duplicate, is \$1.00. This price includes mailing, postage and sales tax.

cal Evangelists; Vernon C. Luthas, Columbus, College of Medical Evangelists; Eaton M. MacKay, Gallipolis, Stanford University; Richard C. Mandeville, Mansfield, St. Louis University; Samuel Martin, Univ. of Basel, Switzerland; John J. McGloin, Cincinnati, Loyola University; Mary T. McGloin, Cincinnati, Loyola University; Ralph F. Morton, Marion, Univ. of Tennessee;

Reuben R. Nichols, Jr., Canton, Howard University; Alden R. Parker, Shaker Heights, Univ. of Michigan; James M. Pfeifer, Indiana University; Tibor A. Pollerman, Sandusky, Univ. of Budapest, Hungary; Charles B. Reiner, Columbus, Temple University; Irving M. Rosen, Cleveland, Boston University; Burton A. Russman, Cincinnati, Northwestern University;

Robert A. Schobinger, Cleveland, Univ. of Lausanne, Switzerland; Jack Schwartz, Univ. of Ghent, Belgium; Julius Silberger, Jr., Cleveland, Univ. of Chicago; Maurice L. Snell, Cleveland, University of Alberta;

John R. Van der Veer, Jr., Toledo, McGill Uni-

versity; Karl D. Venters, Cleveland, University of Illinois; Jan P. Vette, Univ. of Amsterdam, Netherlands; Adolph F. Znidarsic, Cleveland, Loyola University; Anthony Zukowsky, Univ. of Krakow, Poland.

U. S. Food and Drug Commissioner George P. Larrick received the 1958 annual award of Pharmaceutical Manufacturers' Assn. Larrick began career with FDA in 1928, became commissioner in 1954.

Brig. Gen. Floyd L. Wergeland, Medicare director, has warned that civilian physicians must decide for themselves if a patient is eligible for care under the reduced program, adding that the special permits issued to dependents living with their sponsors "do not necessarily specify the treatment covered." He cautioned physicians not to view the permits "as an automatic blanket authorization for care from civilian sources."

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Deprol is unlike central nervous stimulants

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Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: Each tablet contains 400 mg. meprobamate and 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl).

Supplied: Bottles of 50 scored tablets.

1. Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. 2. Current personal communications; in the files of Wallace Laboratories.

Literature and samples on request  **WALLACE LABORATORIES, New Brunswick, N. J.**

Auxiliary By-Laws Changes . . .

Revised Code Prepared by Special Committee Will Be Acted On By House of Delegates at 1959 Annual Meeting in Columbus During April

AT THE 1959 Annual Meeting of The Woman's Auxiliary to the Ohio State Medical Association, in Columbus, the week of April 19, the House of Delegates of that organization will be requested to adopt a revised Code of By-Laws which, if adopted, will take the place of its current Constitution and By-Laws.

A revisions committee has been working on the document. Personnel of the committee is Mrs. Karl F. Ritter, Lima, chairman; Mrs. C. A. Colombi, Cleveland; Mrs. V. R. Frederick, Urbana; Mrs. E. Paul Greenawalt, Springfield; Mrs. George O. Kress, Columbus, and Mrs. C. H. Bell, Mansfield, President, ex-officio.

Following are the revised By-Laws, prepared and recommended by the committee, for action by the Auxiliary House of Delegates in April:

ARTICLE I—NAME

The name of this organization shall be: "The Woman's Auxiliary to the Ohio State Medical Association." (Hereinafter referred to as the State Auxiliary)

ARTICLE II—OBJECTS

The objects of the State Auxiliary are:

- (1) To cooperate with the Ohio State Medical Association in advancing its aims and to carry on any activities it may suggest or approve for the Auxiliary;
- (2) To coordinate and advise concerning the activities of component Auxiliaries;
- (3) To unite with similar organizations in other states to constitute the Woman's Auxiliary to the American Medical Association;
- (4) To promote good fellowship among physicians' families.

ARTICLE III—COMPONENT AUXILIARIES

Section 1. A woman's auxiliary in any county, which has been organized with the written approval of the component medical society of the Ohio State Medical Association in that county, shall be deemed a component of the State Auxiliary upon approval of its Constitution and/or Bylaws and its form of organization by a committee consisting of the President, President-Elect, and 1st Vice-President of the State Auxiliary.

Section 2. There shall be only one component auxiliary in each county.

Section 3. Each component auxiliary shall request its county medical society to appoint a committee of its members to act as an advisory committee to the auxiliary. The auxiliary must have the advice and consent of the advisory committee before undertaking any project.

Section 4. An amendment to the Constitution and/or Bylaws of any component auxiliary shall be submitted to a committee consisting of the State President, President-Elect, and 1st Vice-President for approval, and no change shall become effective until such approval has been given.

Section 5. Component auxiliaries shall be grouped in districts corresponding to the Councilor Districts of the Ohio State Medical Association.

ARTICLE IV—MEMBERSHIP

Section 1. The membership of the State Auxiliary shall consist of

- (1) Active members and
- (2) Honorary members.

Section 2. Active members shall be wives of members in good standing of a component society of the Ohio State Medical Association and widows of members of that Association or of any other state medical society who, at the time of their decease, were in good standing.

A wife must be a member of the component auxiliary of the county in which her husband holds membership; a widow must be a member of the component auxiliary of the area of her residence. A component auxiliary shall judge the qualifications of its members.

No one may be an active member of two component auxiliaries at the same time.

A woman eligible for membership, residing in a county in which there is no organized auxiliary, may become a member-at-large of the State Auxiliary, providing her request to become a member has the approval of the Councilor of her district and she pays her state and national dues.

Nothing in this section shall be construed as retroactive.

Section 3. Honorary members. Members who have rendered long and signal service to the State Auxiliary may become Honorary members by action of the House of Delegates upon recommendation of the Board of Directors. An Honorary member shall enjoy all the privileges of active membership without payment of state dues. The State Auxiliary shall pay the dues of such members to the National Auxiliary.

ARTICLE V—DUES

Section 1. Annual per capita dues and all assessments of the State Auxiliary shall be determined by the House of Delegates and shall be payable by January 1 of the calendar year for which such dues are levied. Failure to transmit such dues prior to January 15 shall deprive a component auxiliary of its representation and right to vote in the House of Delegates for that year.

Section 2. Each component auxiliary shall establish its own annual dues, at least sufficient to cover the annual State and National dues.

Section 3. A member of the State Auxiliary who has been dropped from the membership roll for nonpayment of dues, can be reinstated by payment of State and National dues for the year when her dues became delinquent and for the current membership year.

Section 4. The membership year shall be from January 1 to December 31.

ARTICLE VI—MEETINGS

Section 1. The State Auxiliary shall hold an annual meeting or convention at the same time and in the same city as that of the annual meeting of the Ohio State Medical Association.

Section 2. A conference of Presidents, Presidents-elect and county chairmen shall be held annually.

Section 3. Special meetings may be called by a 2/3

vote of the Board of Directors or upon petition of at least 20 component auxiliaries.

ARTICLE VII—HOUSE OF DELEGATES

Section 1. The House of Delegates is the legislative body of the State Auxiliary. It shall meet annually at the time and place of the annual meeting of the State Auxiliary and shall transact all business of the State Auxiliary not otherwise specifically provided for in these Bylaws.

Section 2. Composition. The House of Delegates is composed of voting delegates, as follows:

(a) Elected officers and Standing Committee Chairmen of the State Auxiliary

(b) Past-Presidents of the State Auxiliary

(c) The President or President-Elect of each County Auxiliary.

(d) In addition, each County Auxiliary shall have one delegate and one alternate for each 100, or fraction thereof, paid members in good standing as defined in Article V, Section 1. An alternate may be seated in the absence of a delegate; after an alternate has been seated she cannot be replaced.

Section 3. Quorum. A majority of the registered delegates shall constitute a quorum.

Section 4. The House of Delegates shall elect representatives to the annual Convention of the National Auxiliary in accordance with the Bylaws of the National Auxiliary.

Section 5. The order of business for sessions of the House of Delegates shall be determined by the Board of Directors. At any meeting, the House of Delegates may change the order of business by a 2/3 vote of the members present.

Section 6. Not less than 60 days prior to the annual meeting, the President, with the approval of the Board of Directors, shall appoint from among members of the House of Delegates such committees as are necessary for the work of the current year's meeting.

Section 7. All resolutions from component auxiliaries shall be referred to the Committee on Resolutions no later than 30 days before the annual meeting. This committee shall analyze them and report them back to the House of Delegates with such recommendations as may be considered by the committee to be advisable.

At the first business meeting only, emergency resolutions may be presented from the floor if consent has been given by the Advisory Committee and by a 2/3 vote of the members present and voting in the House of Delegates.

Section 8. Referendum. By a 2/3 vote of members present at any meeting of the House of Delegates the State Auxiliary may order a general referendum on any question pending before it. Such referendum shall be conducted in a manner similar to that set forth in the Constitution and Bylaws of the Ohio State Medical Association.

Section 9. All members of the State Auxiliary shall be entitled to attend the sessions of the House of Delegates, to report to, or address the House of Delegates or to discuss the pending business but only voting delegates may introduce business or vote.

ARTICLE VIII—OFFICERS

Section 1. Designations:

(a) The elected officers of the State Auxiliary shall be a President, a President-Elect, the immediate Past-President, a First, Second, and Third Vice-President, a Recording Secretary, a Treasurer and a District Councilor from each of the eleven Councilor Districts.

(b) The appointed officers shall be a Corresponding Secretary and a Parliamentarian.

Section 2. Term of Office:

(a) The President-Elect and the three Vice-Presidents shall be elected annually by the House of Delegates and shall serve for one year or until their successors are elected and installed.

(b) The President shall serve for one year and shall be

succeeded by the President-Elect. The immediate Past-President shall serve for one year as a member of the Board of Directors.

(c) The Recording Secretary, the Treasurer and the District Councilors shall each serve for two years. The Recording Secretary and the District Councilors representing the even-numbered districts shall be elected in even-numbered years; the Treasurer and the District Councilors representing the odd-numbered districts in the odd-numbered years.

Section 3. Nominations and Election:

(a) Nominating Committee. On the first day of the annual meeting, the House of Delegates shall elect a Nominating Committee of seven members, two of whom shall be from the Board of Directors and five from the body of the House of Delegates, who shall not be members of the Board of Directors. The election shall be by ballot and the Board member receiving the highest number of votes shall serve as Chairman of the Committee. There shall be nominated at least three from the Board and eight from the House of Delegates. The Board member receiving the third highest number of votes shall serve as alternate for the Board member and the Delegates placing sixth, seventh, and eighth shall serve as alternate Nominating Committee members in that order. No member of this committee shall serve two consecutive years and no component Auxiliary shall have representation on this committee two consecutive years. Only one name from any component Auxiliary may be placed in nomination.

(b) Not later than 90 days before the next annual meeting, the Nominating Committee shall meet and prepare a slate containing the name of one or more members for each of the offices to be filled. This slate shall be sent to each component auxiliary at least 30 days before the annual meeting. At the first meeting of the House of Delegates, the Nominating Committee shall present this slate to be the subject of an election at the last meeting of the House of Delegates.

(c) Nominations may also be made from the floor. No name may be placed in nomination without the consent of the nominee.

(d) All elections shall be by ballot and a plurality vote shall elect. When there is no contest, the election may be by oral vote.

Section 4. Vacancies:

Vacancies in any elective office, except that of President or President-Elect, occurring between the annual meetings shall be filled by a majority vote of the Board of Directors. In case of the death or resignation of the President, the President-Elect shall immediately become President and shall serve for the remainder of the term of her immediate predecessor. If the time served is less than nine months, she shall also serve as President until the second annual meeting following her election as President-Elect. If she succeeds to the Presidency nine months or more before the following annual meeting, the House of Delegates at that following annual meeting shall elect another eligible person to serve as President until the next annual meeting. If there is a vacancy in the offices of both President and President-Elect, the 1st Vice-President shall act as President until the next annual meeting at which time the House of Delegates shall elect a President. In case of the death or resignation of the President-Elect, that office shall remain vacant and at the next annual meeting the House of Delegates shall elect a President.

Section 5. Duties of Elected Officers:

(a) The duties of the officers shall be such as are implied by their respective titles, and specified in these Bylaws and prescribed by the House of Delegates or Board of Directors.

(b) The President shall

(1) Preside at all meetings of the Board of Directors, the State Auxiliary and the House of Delegates.

(2) Be a member ex-officio of all committees except the Nominating Committee.

(3) Appoint, with the approval of the Board of

Directors, the appointed officers and the chairmen of all standing committees except where these Bylaws provide to the contrary.

(4) Appoint, with the approval of the Board of Directors, such special committees as may be deemed necessary.

(5) Co-sign with the Finance Chairman, a written order for all disbursements by the Treasurer.

(c) The President-Elect shall

(1) Automatically become President upon completion of her term as President-Elect.

(2) Be Membership Chairman.

(3) Be an ex-officio member without the right to vote of all committees except the Nominating Committee.

(d) Vice-Presidents.

(1) The First Vice-President shall assume the duties of the President during the absence or disability of the latter.

(2) The 3 Vice-Presidents must each represent a different geographical section of the state and be responsible for membership and organization in her respective section.

(e) Past-President—Immediately upon expiration of her term of office, the President as Immediate Past-President shall serve as a member of the Board of Directors for one year.

(f) Recording Secretary—The Recording Secretary shall

(1) Keep a record of all meetings of the State Auxiliary and of the Board of Directors.

(2) Be custodian of official records and reports.

(3) Conduct such other duties as may be required or ordered by the Board of Directors.

(4) Continue to function for one month after the Annual Meeting at which her successor is elected and installed to complete her year's work.

(g) Treasurer—The Treasurer shall

(1) Be custodian of the funds of the State Auxiliary, including per capita dues collected by and transmitted to her by the component auxiliaries or received from members-at-large.

(2) Disburse funds only upon written order signed by the President and the Chairman of the Finance Committee.

(3) Submit a financial report at each meeting of the Board of Directors and at the annual meeting of the State Auxiliary.

(4) Keep a complete accounting and membership record.

(5) Give bond in such amount as shall be determined by the Board of Directors, the expense to be borne by the State Auxiliary.

(6) Submit the Treasurer's accounts for an annual audit by a certified public accountant.

(7) Serve as a member of the Budget and Finance committee.

(8) Continue to function for one month after the Annual Meeting at which her successor is elected and installed to complete her year's work. An interim audit shall be made at the same time for the protection of the incoming Treasurer.

(h) District Councilors—Each District Councilor shall keep in touch with the component auxiliaries in her district, giving assistance whenever necessary and serving as liaison between them and the State Auxiliary. She shall visit each county in her district at least once each year.

Section 6. Duties of Appointed Officers:

(a) The Corresponding Secretary shall

(1) Carry on the official correspondence of the Auxiliary.

(2) Conduct such other duties as may be required by the Board of Directors.

(3) Be a member, ex-officio without the right to vote, of the Board of Directors.

(b) The Parliamentary shall

(1) Attend all meetings of the House of Delegates and the Board of Directors.

(2) Advise, when requested, the President, the Board of Directors and any committee, officer or member on parliamentary questions concerning the Auxiliary.

(3) Be a member, ex-officio, without the right to vote, of the Board of Directors.

ARTICLE IX—BOARD OF DIRECTORS

Section 1. The Board of Directors shall consist of the elected officers, the Corresponding Secretary and the Parliamentary, both of whom shall be ex-officio, non-voting members.

Section 2. Duties—The Board of Directors between annual meetings shall

(a) Carry out the mandates and policies of the State Auxiliary as determined by the House of Delegates.

(b) Have full and complete power and authority to perform all acts and to transact all business for or on behalf of the State Auxiliary, subject only to the provision of the Bylaws, action of the House of Delegates, and instructions of the Advisory Committee.

(c) Approve the budget before it is presented to the House of Delegates.

(d) Be permitted in an exigency to vote by mail.

Section 3. Quorum and Meetings—

(a) Twelve members of the Board of Directors shall constitute a quorum.

(b) The Board of Directors shall hold at least four meetings annually; immediately before and after each Convention and in the fall and winter quarters.

(c) The President may call a special meeting of the Board of Directors on her own motion and must call one on the written request of five of its members.

ARTICLE X—COMMITTEES

Section 1. The Standing Committees of the State Auxiliary shall include committees to correspond with the standing committees of the National Auxiliary (Article XI, Section 1 of the National Bylaws) and any other committees necessary to conduct the business of the State Auxiliary.

Section 2. The Chairmen of the Standing Committees shall attend the pre-Convention and Fall quarter meetings of the Board of Directors.

Section 3. All Standing Committee Chairmen shall have the privilege of requesting to be heard by the Board of Directors at any Board meeting.

Section 4. All Standing Committee Chairmen shall report in writing to the Board of Directors at each meeting of the Board.

ARTICLE XI—PARLIAMENTARY AUTHORITY

The rules of parliamentary practice contained in Roberts Rules of Order Revised shall govern all deliberations of the State Auxiliary, subject to the special rules which have been or may be adopted.

ARTICLE XII—AMENDMENTS

These Bylaws may be amended at any meeting of the House of Delegates by a two-thirds vote provided that the proposed amendment has been

(1) Submitted in writing to the Chairman of the Committee on Bylaws at least six months before the meeting at which it is to be acted upon.

(2) Approved by The Council of the Ohio State Medical Association.

(3) Published in the State Auxiliary's official publication.

(4) Sent to the President of each component auxiliary at least one month before the meeting at which it is to be acted upon.

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CASES
RESPOND TO

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REFRACTORY CASES RESPOND

In Memoriam . . .

Philmour M. A. Bein, M. D., Mansfield; University of Pennsylvania School of Medicine, 1932; aged 52; died January 9; member of the Ohio State Medical Association, the International College of Surgeons and the Industrial Medical Association; diplomate of the American Board of Surgery. Dr. Bein was a practicing physician in Mansfield since 1936. He was a veteran of World War II, having served in the South Pacific theater from 1944 to 1946. Survivors include his mother, a brother and five sisters.

George D. Blydenburgh, M. D., Byesville; University of Cincinnati College of Medicine, 1946; aged 37; died December 28; member of the Ohio State Medical Association and the American Medical Association. Dr. Blydenburgh had been practicing in Byesville since 1957 and prior to that was on the staff of the Cambridge State Hospital for two years. A veteran of World War II, he is survived by his mother, a brother and a sister.

William J. Coulter, M. D., Toledo; Toledo Medical College, 1900; aged 91; died December 11. A resident of Toledo since his boyhood, Dr. Coulter served all of his professional career there. He retired about 12 years ago. Affiliations included memberships in the Methodist Church and several Masonic bodies. Surviving are two brothers.

Dora Horn Cowell, M. D., Winter Park, Fla.; Cleveland-Pulte Medical College, 1906; aged 75; died December 19. Dr. Cowell practiced under her maiden name in Bellevue until 1917 when she enlisted with the Army and went overseas during World War I. After the war she began practice in Cleveland and in 1925 married Howard U. Cowell, who survives. The couple resided in Lakewood until about two years ago. Two sisters also survive.

Charles Louis Critchfield, M. D., Waverly; Ohio State University College of Medicine, 1938; aged 46; died December 30; member of the Ohio State Medical Association. Dr. Critchfield had been a practicing physician in the Waverly area since 1947. Prior to that he was on the staff of the Orient State School. Surviving are his widow, two sons, his parents and a sister.

Harry E. Dickson, M. D., Marietta; Ohio State University College of Medicine, 1914; aged 70; died December 27 in Tucson, Ariz., following a traffic accident in November; former member of the Ohio State Medical Association. A native of

the area, Dr. Dickson returned to Marietta in 1942. Prior to that he practiced in Lebanon, Waterford and Matamoras. While in Marietta he served as Washington County coroner and as county health commissioner. He was a member of the Methodist Episcopal Church, several Masonic bodies and other organizations. Surviving are his widow, four daughters and a sister.

Alpha Fritz Hawk, M. D., Grant (Micco), Florida; Ohio State University College of Homeopathic Medicine, 1919; aged 62; died December 23; former member of the Ohio State Medical Association. A practicing physician in Urbana from 1933 until he went into service during World War II, Dr. Hawk was a past-president of the Champaign County Medical Society. An Army Medical Corps major, he served with the 334th Station Hospital in New Guinea. At the close of the war, he became a medical examiner for the Veterans Administration in Jacksonville, Fla., remaining there until his retirement in 1949. He was a member of the Masonic Lodge. Surviving are his widow and three daughters.

Normand L. Hoerr, M. D., Cleveland; University of Chicago School of Medicine, 1931; aged 56; died December 14. Dr. Hoerr was the Henry Wilson Payne professor of anatomy at Western Reserve University School of Medicine. He came to Western Reserve from the University of Chicago in 1939. Nationally known for his contributions to medical literature, he was co-editor of the Blackiston-Gould Medical Dictionary and associate editor of several texts. Associations included memberships in several fraternal and professional organizations. His widow survives.

Malcolm H. Koehler, M. D., Newark; Ohio Medical University, Columbus, 1900; aged 84; died December 29; former member of the Ohio State Medical Association. Dr. Koehler in 1944 completed 42 years as medical examiner for the Baltimore & Ohio Railroad. He had been in Newark since 1917. In recent years he served as Licking County coroner. He was a member of the Ohio State Coroners' Association, the United Spanish War Veterans, the Presbyterian Church, several Masonic Lodges and the Knights of Pythias. Survivors include his widow, four sons, three daughters and a brother.

Arnold M. Landsborough, M. D., Garrettsville; University of Toronto Faculty of Medicine, 1925; aged 63; died December 4; former member of the Ohio State Medical Association. Dr. Lands-

borough had been a practicing physician in the Garrettsville area since 1928. A native of Canada, he served with the Canadian Air Force during World War I. His widow survives.

Otto Mikolanda, M. D., Lorain; University of Wooster, Medical Department, Cleveland, 1903; aged 80; died January 5. Before World War I, Dr. Mikolanda practiced in Cleveland and Lorain. After serving in the Army Medical Corps in Europe and as translator for the Paris Peace Conferences, he returned to Lorain. He was a member of the American Legion. Two sons and a sister survive.

Edwin F. Moore, M. D., Cincinnati; University of Cincinnati College of Medicine, 1912; aged 69; died December 29; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Moore practiced medicine in Cincinnati for more than 40 years. He was a member of the Masonic Lodge. Survivors include his widow, a son and a daughter.

Whitelaw R. Morrison, M. D., Oberlin; Columbia University College of Physicians and Surgeons, 1914; aged 72; died December 26. From 1923 to his retirement in 1952, Dr. Morrison was professor of anatomy at Oberlin College and director of the physical education department. He was a member of the American Physical, Educational and Recreational Association, the Masonic Lodge and the Congregational Church. Surviving are his widow, four daughters and a brother.

Ralph C. Paisley, M. D., Loudonville; Ohio State University College of Medicine, 1930; aged 54; died December 24; member of the Ohio State Medical Association and the American Medical Association. Dr. Paisley had been a practicing physician in Loudonville since 1931, with time out for service in the Medical Corps during World War II, during which he attained the rank of major. In addition to his professional affiliations, he was a member of the Presbyterian Church, the Masonic Lodge and the American Legion. Survivors include his widow, a son, his mother, and a brother, Dr. C. Glenn Paisley, also of Loudonville.

John Wesley Wentz, M. D., Pataskala; Ohio State University College of Medicine, 1910; aged 73; died December 31; member of the Ohio State Medical Association and the American Medical Association. Dr. Wentz served virtually all of his professional career of 48 years in the Pataskala area. Active in civic affairs, he was president of the local school board for several years. He also was a member of the Presbyterian Church and sev-

eral Masonic bodies. Surviving are his widow, a daughter, two sons, four brothers and four sisters.

Samuel A. Young, M. D., Cleveland; Western Reserve University School of Medicine, 1904; aged 79; died December 30; member of the Ohio State Medical Association and the American Medical Association. Dr. Young had been a practicing physician in the Newburgh section for 54 years and had been honored with the 50-Year Award of the OSMA. He was active in many civic affairs; was a past-president of the local Kiwanis Club, member of the Masonic Lodge, the Independent Order of Foresters and the Presbyterian Church. Surviving are his widow, a son and a daughter.

To Get Paid You Must Send In Original Bill, Not Copy

The Auditor of State's office has advised the Division of Aid for the Aged that reproductions of original invoices (statements) submitted by those rendering services to the aged under the Health Care Program of the DAA will no longer be acceptable to that office.

The Auditor has interpreted the law to require that original invoices (bills) must be filed with him before he can draw payment vouchers.

Therefore, physicians should keep this in mind in billing for services rendered aid for the aged recipients, namely: Send the original bill, and two copies.

The same policy should be followed by physicians in submitting bills to other state agencies, namely, submit the original and the number of copies required by the agency.

A symposium on smoking and lung cancer and another on pulmonary emphysema will be among the highlights of the 54th Annual Meeting of the American Trudeau Society, medical section of the National Tuberculosis Association, which will be held in Chicago, Ill., May 25-28. The ATS will meet in conjunction with the NTA. All sessions will be at the Palmer House, where scientific and public health exhibits will also be displayed.

Of the 187,800 male veterans hospitalized in all public and private hospitals as of June, 1957, only 39,000 were being treated for service-connected conditions. Nearly three out of every five veterans who needed hospital care received it from the VA. By 1986 the non-service connected load is expected to reach 304,500 if present admission policies are not altered.

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Range is from 125 mg. (200,000 units) three times daily to 250 mg. (400,000 units) every four hours. Children's dosage is determined by body weight. When combined with sulfa triad, range is one Filmtab three times daily to two Filmtabs every four hours.

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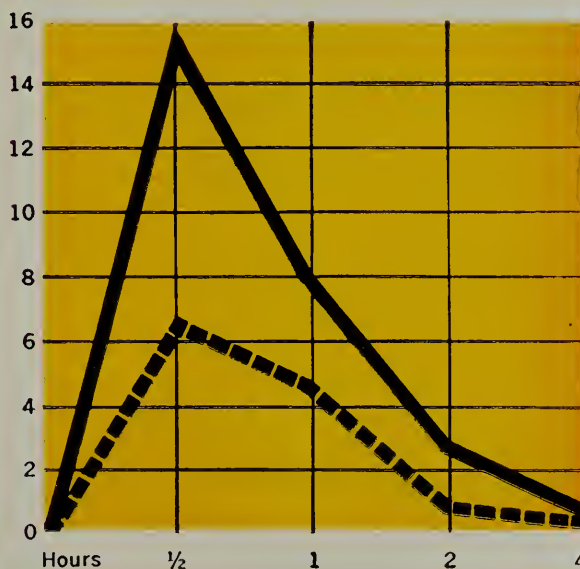
COMPOCILLIN-VK Filmtabs: 125 mg. (200,000 units), bottles of 50 and 100; 250 mg. (400,000 units), bottles of 25 and 100.

COMPOCILLIN-VK Granules for Oral Solution: In 40-cc. and 80-cc. bottles. When reconstituted, each tasty 5-cc. teaspoonful of cherry-flavored solution represents 125 mg. (200,000 units) of potassium penicillin V.

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Activities of County Societies . . .

First District

(COUNCILOR: CHARLES W. HOYT, M. D.,
CINCINNATI)

BUTLER

Two Butler County physicians, Dr. David F. Gerber and Dr. John C. Stratton, both of Middletown, were honored Wednesday night (Dec. 4) for 50 years of practice in the medical profession.

The honors were conferred at a meeting of the Butler County Medical Society held in Hughes Memorial Hospital, Hamilton, with Dr. Charles Hoyt, of Cincinnati, First District Councilor of the Ohio State Medical Association, presenting 50-year service pins to Dr. Gerber and Dr. Stratton.

Also scheduled to receive 50-year honors at Wednesday night's meeting was Dr. Malcolm Bronson, of Hamilton, who was unable to attend the meeting because of illness.

The meeting, the last of the year, was conducted by Dr. John Perkins, Middletown, president. Regular reports of special committees were given.—*Hamilton Journal*.

CLINTON

Dr. Robert M. Cronebaugh of Blanchester was elected president of the Clinton County Medical Society at the Tuesday (December 3) luncheon meeting at the General Denver hotel. He succeeds Dr. Roy D. Goodwin.

The report on the improvement in health and immunization in Wilmington and Clinton county revealed in the survey made by the county Health Council this summer was given by Dr. E. K. Yantes. The improvement was made over a period of several years since the original survey was made in city and county.

Other officers elected are Dr. Maxine Hamilton, vice-president; Dr. John K. Williams, secretary-treasurer; Dr. Yantes, delegate to the state medical association and Dr. Thomas M. Faehnle, alternate delegate.

Drs. Foster J. Boyd and Nathan S. Hale comprised the nominating committee.—*Wilmington News Journal*.

HAMILTON

A Symposium, "How a Drug Is Born," comprised the scientific program at the January 13 meeting of the Academy of Medicine of Cincinnati. Panelists consisted of Drs. C. W. Pettinga, R. S. Griffith and H. M. Higgins, Jr., all associated with the Eli Lilly Company, and Mr. R. C. Anderson, secretary of the American Pharmaceutical Association. Moderator was Dr. Don Carlos Hines, who is associated with the Lilly Company.

Dr. Charles W. Metz, a practicing physician in the Northside area of Greater Cincinnati, was honored in November by the Academy of Medicine of Cincinnati. Dr. Frank H. Mayfield, President-Elect of the Ohio State Medical Association, presented the OSMA 50-Year Award to Dr. Metz. Other 50-Year Awards were presented at a meeting of the Academy earlier in the month.

Dr. Mayfield also presented the 50-Year Award to Dr. Earl S. Simmonds who has been living in Florida and was not present when awards were presented. Dr. Simmonds is a graduate of the Medical College of Ohio, Class of '07. The presentation was made on a visit to Cincinnati.

HIGHLAND

Dr. Lena Holladay, of Hillsboro, was named president-elect of the Highland County Medical Society at the November meeting. Dr. J. Martin Byers was installed as president. Re-elected secretary-treasurer was Dr. Kenneth Upp, Greenfield.

At the January meeting of the Highland County Medical Society in Hillsboro, guest speaker was Dr. Thomas Hancock, Fayette County Memorial Hospital, Washington C. H., who presented a paper on the management of gall bladder disease in small community hospitals.

Second District

(COUNCILOR: R. DEAN DOOLEY, M. D., DAYTON)

DARKE

The regular monthly meeting of the Darke County Medical Society was held on January 20 in Greenville. The subject, "Indications for Open Cardiotomy," was discussed by Drs. Robert Taylor and William Porter, of Dayton.

MONTGOMERY

A concert by the M. C. M. S. Glee Club was a feature of the Annual Inaugural Dinner Meeting of the Society on January 9 at the Biltmore Hotel.

The Inaugural is an annual "Husband and Wife" event and has consistently been the best attended of all M. C. M. S. affairs.

The Glee Club, under the direction of Dr. W. J. Lewis, made its first appearance at the 1958 M. C. M. S. Inauguration. It "brought down the house" and has received state and national recognition since then.

Dr. A. J. Carlson was installed as the 110th President of the Society in the ceremonies following the banquet.

Other 1959 officers installed are Drs. E. W. Smith, president-elect; H. A. Bremen, vice-presi-

dent; N. F. Stambaugh, secretary; P. A. Eckert, treasurer; and L. E. Rausch, trustee.

Those with unexpired terms who remain in office in 1959 are Drs. A. V. Black, immediate past-president; R. Dean Dooley, chairman of Presidents Committee; L. E. Baker and M. S. Jones, trustees.

Dr. John Worthman, 1958 chairman of the Public Relations Committee, was program chairman for the Inaugural. Dr. A. J. Brogan is general program chairman for 1959.

Dr. R. Dean Dooley, OSMA Second District Councilor, awarded certificates and lapel pins to four MCMS members each of whom in 1958 completed 50 years in medicine. They are: Drs. W. B. Bryant, P. H. Kilbourne, J. K. Larkin, and H. W. Lautenschlager.

Dr. Charles E. O'Brien introduced the guest speaker: Henry A. DeWire, Ph. D., professor of christian education and psychology, United Theological Seminary.

PREBLE

Dr. E. P. Trittschuh, Lewisburg physician, has been re-elected president of the Preble County Medical Society.

This marks Dr. Trittschuh's second consecutive year in office. The election was held during a dinner meeting for members of the society and their wives at the Whispering Oak Restaurant here.

Elected secretary-treasurer was Dr. B. R. Smith, another Lewisburg practitioner. Smith succeeds Dr. B. R. Bowman who closed his practice in Eaton during the year and moved to Colorado.—*Eaton Register Herald*.

Third District

(COUNCILOR: FLOYD M. ELLIOTT, M. D., ADA)

HARDIN

The Hardin County Medical Society and Auxiliary were entertained at San Antonio Hospital Thursday (Dec. 11) where they were served a Christmas turkey dinner by the hospital personnel.

Intricately woven ribbons outlined Christmas trees bearing the golden initials, SAH. Favors of Christmas corsages were given to the group.

A selected group of Kenton high school choir students, under the direction of John Roberts, sang carols for the entertainment.

The auxiliary and society announced the annual Mistletoe Ball Dec. 27. Donations of \$10 per couple go for the benefit of Kenton's two hospitals.—*Kenton Times*.

LOGAN

Dr. Charles Browning, Bellefontaine, has been named president of the Logan County Medical Society, succeeding Dr. Frederick W. Kaylor, also of this city.

Other officers elected for 1959 include Dr. John Wolf, West Liberty, vice-president, and Dr. Paul Hooley, DeGraff, secretary-treasurer.—*Bellefontaine Examiner*.

MERCER

The Mercer County Medical Society held its annual meeting in November and elected the following officers: Dr. Julius Schwieger, of Fort Recovery, president; Dr. Louis J. Finkelmeier, Celina, vice-president; and Dr. Terrence J. Kerrigan, Coldwater, secretary and treasurer.

The Society's Christmas party was held on December 7 at the Northmoor Country Club.

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

LUCAS

The 57th annual meeting of the Academy of Medicine of Toledo and Lucas County was held on January 14 at the Commodore Perry Hotel in Toledo. Guest speaker was Harlan Hatcher, Ph. D., president of the University of Michigan, and author of several novels and historical articles dealing with the Great Lakes area.

During December the following specialty sections held programs:

General Section, December 5—annual business meeting, with committee reports.

Pathology Section: December 12. The topic "Certain Aspects of Thyroid Carcinoma," was discussed by Dr. Robert C. Horn, Jr., pathologist-in-chief at the Henry Ford Hospital, Detroit.

Medical Section, December 19. The subject, "Practical Aspects of Evaluating Pulmonary Function," was discussed by Dr. H. L. Hook, Toledo Clinic.

PUTNAM

December meeting of Putnam County Medical Society was held at Ottawa, Tuesday, Dec. 5.

Guest speaker was Dr. Thomas J. Roess, Lima internist. Dr. Roess spoke on the subject, "Errors in Diagnosis of Pulmonary Disease." He presented a report of 5200 cases admitted to a large general hospital with a diagnosis of tuberculosis. He discussed the many errors which had been made in the admitting diagnosis of these cases.—H. N. Trumbull, M. D., Correspondent.

SANDUSKY

Dr. Allen Eyestone, of Gibsonburg, was elected 1959 president of the Sandusky County Medical Society during the December meeting Wednesday night at Serwin's restaurant, North Fifth Street, Fremont.

Other officers elected were Dr. Robert Borden,

vice-president, and Dr. Paul Burson, of Bellevue, secretary-treasurer.

Guest speaker for the evening was Dr. Thomas Schoepfle, of Sandusky, who spoke on "Common Skin Diseases."

Dr. C. E. Swint presided.—*Fremont News Messenger*.

WOOD

Dentists of the county were guests of the Wood County Medical Society when it held its Christmas party December 17 at the Carranor Hunt and Polo Club in Perrysburg. The dinner and evening of entertainment was attended by members, guests and the ladies.

Fifth District

(COUNCILOR: GEORGE W. PETZNICK, M. D.,
CLEVELAND)

CUYAHOGA

The second annual joint holiday meeting of the Academy of Medicine of Cleveland and the Cleveland Bar Association was held on December 10. This was a meeting of members and their ladies.

Guest for the occasion was Commander and Mrs. James F. Calvert. Commander Calvert described the history making scientific journey of the atomic submarine Skate under the ice of the North Pole.

Fifty-Year Buttons were presented to six physicians at a recent meeting of the Academy of Medicine of Cleveland. They are: Dr. Ernest R. Brooks, Dr. C. W. Wyckoff, Dr. Albert G. Schlink, Dr. Ralph A. Scherz, Dr. Everett P. Coppedge and Dr. John F. Evens. Also honored for half-century as a doctor was Dr. H. W. Massenhimer, who was not able to be present.

LAKE

Dr. Richard W. McBurney, of Painesville, was elected president of the Lake County Medical Society for 1959 at a recent meeting.

Other officers are: Dr. Gordon W. Hasse, of Madison, vice-president; Dr. Harry A. Killian, of Willoughby, secretary and treasurer; Dr. J. W. Koelliker, Jr., of Willoughby, censor; Dr. Benjamin S. Park, Painesville, delegate, and Dr. James G. Powell, Painesville, alternate.

Mrs. Owen A. McLaren, of Mentor, is Executive Secretary of the Lake County Medical Society.—*Madison Press*.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D.,
YOUNGSTOWN)

MAHONING

Dr. M. W. Neidus was elected president of the Mahoning County Medical Society at the annual election of officers in the Elks' Club December 16, succeeding Dr. Andrew A. Detesco. Dr. F. G. Schlecht was named president-elect.

Other new officers include Dr. A. K. Phillips, secretary, and Dr. C. W. Stertzbach, treasurer. Dr. Detesco inherited the newly created post of immediate past-president. Delegates to the Ohio State Medical Association are Drs. P. J. Mahar, H. P. McGregor, G. E. DeCicco and Asher Randell. Alternates are Drs. C. C. Wales, J. J. McDonough, R. R. Fisher and S. W. Ondash.

Named as members of the council-at-large are Drs. McGregor, Ondash, DeCicco, Mahar, M. S. Rosenblum, H. J. Reese, C. E. Pichette and F. A. Resch. Dr. L. O. Gregg was appointed by Dr. Neidus as editor of *The Bulletin* and as such is entitled to a vote on the council. Dr. J. M. Ranz was re-elected representative to the Associated Hospital Service.

About 120 persons attended the meeting and heard a talk by two representatives of the Youngstown Area Chamber of Commerce, J. Paul Mossman, executive director, and Edward J. Hulme, executive assistant. Both urged greater community



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participation in the work of the Chamber.—*Youngstown Vindicator*.

PORTAGE

The Portage County Medical Society held its annual banquet on December 3 at the Aurora Inn, Ravenna. Dr. James L. Kocour, Cleveland, was guest speaker and explained the therapeutic and recreational values of expressing oneself through the medium of art. He was assisted by Alex Dery, artist.

STARK

Dr. John R. Seesholtz of Canton was elected president of the Stark County Medical Society at a Thursday evening (Dec. 12) meeting attended by 150 members at the Belden Hotel, Canton.

Dr. Roy H. Clunk of Massillon, retiring president, conducted the meeting. Other officers elected are: Dr. Aubrey Boyles of Louisville, president-elect; Dr. Robert K. Gardner, Canton, secretary-treasurer.

Appointed as delegates (and holdover delegates) are Dr. J. B. Walker, Dr. W. A. White, Dr. Maurice F. Liber and Dr. Seesholtz. Their alternates are Dr. David E. Leavenworth, Dr. Lloyd Dowell, Dr. Mark Herbst and Dr. R. E. Tschantz.

Dr. Max Haas was elected to the board of directors. Board members continuing in office are Dr. Cleon Couch and Dr. G. O. Thompson.

Fred O. Keel of the Federal Reserve bank in Cleveland addressed the group on "Business Trends in 1959."—*Alliance Review*.

A symposium on the management of terminal illnesses was held at the St. Francis and Onesto Hotels, Canton, on January 21. This program was jointly sponsored by the Stark-Carroll Academy of General Practice, Canton Academy of Medicine, and the Stark County Medical Society.

SUMMIT

"Treatment of Rheumatic Fever—Present Status," was the subject discussed at the January 6 meeting of the Summit County Medical Society in collaboration with the Akron District Heart Association. The speaker was Dr. Edward A. Mortimer, Jr., assistant professor of pediatrics at Western Reserve University. Dinner at the Akron City Club was followed by the meeting in the Akron City Hospital auditorium.

TRUMBULL

Dr. Martin Keller, chief of the Chronic Diseases Section of the Ohio Department of Health, was chief speaker when the Trumbull County Medical Society assembled at the El Rio for a dinner meeting on January 21. Dr. Keller discussed future use of the Trumbull County Tuberculosis Hospital.

A special program was held on January 20 in the Assembly Room at Trumbull Memorial Hospital to hear Dr. James B. Donaldson, assistant professor of medicine at Hahnemann Medical College in Philadelphia. Speaking under the auspices of Riker Laboratories, Dr. Donaldson discussed hypertension.

Dr. Clyde Muter was named president-elect at the December meeting of the Society. Dr. Paul Noonan assumed the duties of president, succeeding Dr. Aubrey Sparks. Dr. Peter Jamieson succeeded Dr. Charles Stone as secretary-treasurer.

Delegates re-elected are Dr. Raymond Ralston and Dr. Elmer Caskey, and alternates, Dr. Sigmond Shapiro and Dr. Joseph Gledhill.

Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

BELMONT

The Belmont County Medical Society and the Auxiliary met on December 18 for dinner and a program at the Belmont Hills Country Club. Speaker for the occasion was the Rev. Lawrence H. Hall, St. Paul's Episcopal Church, Cleveland.

JEFFERSON

The Jefferson County Medical Society celebrated its 100th anniversary in the Fall with a dinner and dance at the Steubenville Country Club. A highlight of the celebration was the awarding of the OSMA 50-Year Award to Dr. Fred H. Riney, of Mingo Junction. Dr. George A. Woodhouse, Pleasant Hill, President of the OSMA, made the presentation. Dr. Woodhouse also spoke and congratulated the Society on its 100 years of service to the community.

Dr. Carl F. Goll, Steubenville, president of the local Society, reviewed the organization's history. Approximately 80 persons, including a number of distinguished guests, attended the celebration.

Eighth District

(COUNCILOR: WILLIAM D. MONGER, M. D., LANCASTER)

MUSKINGUM

Dr. Louis Cassidy, president of the Muskingum Academy of Medicine, announced that the society will establish and maintain a medical library in both Good Samaritan and Bethesda hospitals, Zanesville.

The library will be available to all persons actively engaged in the field of health and medicine as well as others who are engaged in medical research projects.

Both hospitals have cooperated with the Medical



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academy by providing space for the libraries and librarians.—*Zanesville Times-Signal*.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

SCIOTO

Officers were chosen by the Scioto County Medical Society December 8 at an election meeting in Portsmouth General Hospital nurses home.

Dr. Ralph W. Lewis was elected president; Dr. Robert N. Counts, vice-president, and Dr. C. H. Laestar, secretary-treasurer.

The new member elected to the society's board of censors was Dr. Samuel L. Meltzer. Dr. Meltzer joins Dr. Dow Allard and Dr. Joseph T. Gohmann on the three-member board.

Elected as the society's state convention delegate was Dr. William M. Singleton. Dr. William E. Daehler was elected alternate delegate.

Dr. Jerome R. Sheets was elected legislative committeeman and Dr. Sol Asch, librarian.

The officers were installed Thursday night at the Society's annual banquet and dance at the Elks City Club auditorium.

SCIOTO

Dr. Harry Ezell, Department of Obstetrics and Gynecology, Ohio State University, was guest speaker at the January 12 meeting of the Scioto County Medical Society in Portsmouth. His subject was, "Endometrial Carcinoma."

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

MADISON

The regular monthly meeting of the Madison County Medical Society was held November 12 in London with Dr. W. T. Bacon presiding. After some discussion an assessment in the amount of \$35.00 per member to cover indebtedness incurred in connection with the recent county hospital drive was authorized. It was decided that any indebtedness in excess of the total received through assessments should be paid from Society funds. A motion that the County Society dues remain at \$5.00 was carried. The remainder of the meeting was devoted to the study of a revised constitution and by-laws.

ROSS

Dr. Lewis T. Franklin, Chillicothe, was honored by being presented the 50-Year Award of the Ohio State Medical Association. Dr. Edwin H. Artman, Councilor for the Tenth District, and Dr. Lewis T. Coppel, president of the Ross County



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70 YEARS OF SERVICE TO THE MEDICAL PROFESSION

Medical Society, made the presentation to Dr. Franklin.

Dr. Franklin began practice in Chillicothe in 1913. He has been Ross County coroner and has been a member of the State Medical Board of Ohio.

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

LORAIN

Dr. Denis A. Radefeld of Lorain was installed president of the Lorain County Medical Society, succeeding Dr. Ben V. Myers of Elyria, at the December meeting.

Other officers elected at the annual meeting at Oberlin Inn are Dr. Harold E. McDonald of Elyria, president-elect for 1960; Dr. John Halley of Vermilion, vice-president;; Dr. Oscar H. Schettler of Oberlin to board of censors, and Dr. G. R. Wiseman of Amherst delegate.

Dr. L. C. Meredith of Elyria was re-elected secretary-treasurer.—*Lorain Journal*.

The January 13 meeting of Lorain County Medical Society was held at the Oberlin Inn, Dr. Denis A. Radefeld presiding. The meeting was attended by 78 persons, including Dr. H. T. Pease, Eleventh District Councilor, and Dr. Howard P. Taylor, guest speaker.

Dr. Peter Volodkevich, pathologist of Elyria, O., was elected to active membership.

Dr. Howard P. Taylor of Cleveland Clinic mesmerized his audience with a scholarly paper on the Use of Hypnosis in Obstetrics and Gynecology.—Lawrence C. Meredith, M. D., Secretary-Treasurer.

Cleveland Hospital Gets Grant For Study of Procedures

Five grants for research in hospital administration and service were announced by the Public Health Service of the Department of Health, Education, and Welfare. The awards, totaling \$76,047, have been approved by the Federal Hospital Council.

The grants are aimed at finding ways to improve the care of patients in hospitals and other health facilities and are made in connection with the Hospital and Medical Facilities Survey and Construction (Hill-Burton) Program. A total of \$4,800,000 has been appropriated for this type of research since 1956.

One grant of \$31,165 is to the Highland View Hospital, Cleveland, for the first year of a four-year study of individual patient need and the care provided in the hospital for patients suffering from severe chronic diseases.

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Activities of Woman's Auxiliary . . .

CHAIRMAN PUBLICITY COMMITTEE—Mrs. W. J. Horger,
1100 Ohio Ave., East Liverpool, Ohio
(See Page 150 for roster of officers.)

CUYAHOGA

The Woman's Auxiliary to the Academy of Medicine of Cleveland will again present annual awards to the outstanding student nurse in each of the 16 schools of nursing. Eleven of these monetary awards are given to regular schools of nursing, and 10 are presented to accredited schools of practical nursing—the latter graduates two classes a year.

The Cuyahoga Auxiliary volunteers time and money to The Council and League for Nursing to further recruitment of nurses and other paramental careers. This unique nursing organization supplies the county with nursing scholarships, enabling the Auxiliary to stimulate nursing in other ways.

Mrs. P. J. Robeck and Mrs. T. H. Borland, Chairmen of awards are in the midst of making plans for the annual Nurse Award Luncheon. Outstanding nurses and their directors will be honored at this meeting.

Cuyahoga wives who rate an R. N. after their name soon will have an opportunity to go on "Special Duty" again. This project is in answer to an urgent call from Red Cross for registered nurses to work at the Blood Center and in Blood-mobile units. Mrs. Rupert B. Turnbull, chairman of the committee, has the promise of some one hundred wives to sign up for the orientation course that will cover blood-testing, hemoglobin estimation, blood pressure, etc.

Five hundred future nurse club members and their advisors met at St. John's College for their fall rally. Auxiliary members acted as hostesses and Mrs. F. Ritinger, president of the Auxiliary, presented the Auxiliary's rotating silver tray trophies to the award winning clubs.

SCIOTO

Yuletide arrangements decorated the home of Mrs. Clyde M. Fitch for the December meeting of the Woman's Auxiliary of the Scioto County Medical Society.

Highlighting the afternoon's entertainment was a miscellaneous auction conducted by William H. Dawson of radio station WNXT. A bake sale was also a part of the afternoon meeting.

Mrs. Armin A. Melior presided at the business session. At the social hour, Mrs. Fitch was assisted

by Mrs. H. A. Green, Mrs. Sol Asche and Mrs. William M. Singleton.

TRUMBULL

The Social Committee entertained the members of the Trumbull County Medical Auxiliary at a Christmas coffee on the morning, December 11. The members were entertained at the home of Mrs. K. J. Williams, whose co-chairman was Mrs. J. E. Burns.

On December 17, the Auxiliary members were entertained by their husbands at a dinner dance at the Squaw Creek Country Club. Members were asked to bring to that meeting presents for the mental patients at state institutions and toys for the playrooms at both local hospitals.

Members of the Trumbull County Medical Auxiliary will serve as "playladies" at St. Joseph Riverside Hospital, every morning starting in January.

Directory of Blood Facilities Published by Joint Council

The first comprehensive directory and description of blood facilities and services ever compiled in this country has been released by the Joint Blood Council, a nonprofit national organization with headquarters in Washington, D. C.

It shows the location of facilities, the extent of their operations, how they are organized, what specific services they offer and other information of importance to physicians, hospitals and any person or organization interested in blood and its derivatives.

The directory is based on data obtained from a questionnaire sent to all known blood banks, hospitals and clinics that offer blood-handling services. The questionnaire was sent to 3,150 institutions and 2,202 replied.

The directory will be distributed free by the council to all institutions and organizations that participated in its preparation, according to Dr. Frank E. Wilson, executive vice-president. Others may obtain it at the cost price of \$1.50 each from the Joint Blood Council headquarters, 1832 M Street, N. W., Washington 6, D. C.

Three Ohioans are scheduled to speak on the program of the International College of Surgeons, Southeastern Regional Meeting of the U. S. Section, in Miami Beach, Fla., January 4-7. They are Dr. Claude S. Beck, Cleveland, and Drs. Richard Brashear and Jay Jacoby, Columbus.



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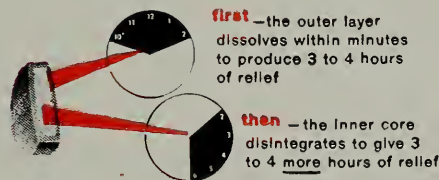
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Medical Staff Appointments . . .

Joint Commission States It Does Not Have Right To Judge Disputes; Appointments to and Government of Staff Are Local Responsibilities

THE Board of Commissioners of the Joint Commission on Accreditation of Hospitals has stated that it desires to indicate to all staffs and interested medical organizations the policy of the Joint Commission when there exists a difference of opinion between the medical staff and the governing body concerning membership on the medical staff. The following statement appeared in Bulletin 19 of the Commission:

The Joint Commission on Accreditation of Hospitals is a voluntary organization. The purpose of the organization expressed in its bylaws does not give the Joint Commission either the legal or the moral right to interfere or adjudicate in local hospital matters.

The question of membership on the medical staff is the primary concern of the governing body and medical staff of the hospital. The governing body has the legal right to appoint the medical staff and the moral obligation to appoint only those physicians who are judged by their fellows to be worthy, of good character, qualified and competent in their respective fields.

Staff Appointments

Privileges may be extended to duly licensed qualified physicians to practice in the appropriate fields of general medicine, surgery, pediatrics, obstetrics, gynecology and other recognized and accepted fields according to the individual experience, competence, ability, character, judgment and ethical regard of the applicant as evaluated by the active credentials committee and recommended by it to the medical staff and to the governing body.

Individual character, competence, experience and judgment should be the criteria for selection. Under no circumstances should the accordance of staff membership or professional privileges in the hospital be dependent solely upon certification, fellowship or membership in a specialty body or society.

Difficult Task

The selection of a medical staff and the delineation of privileges of individual staff members are extremely important responsibilities of the medical staff, and with these responsibilities perhaps goes one of the most difficult tasks which the medical staff must face. It is difficult because there are no easy rules to follow and no well-defined criteria

acceptable to the medical profession in general. It is a problem of each hospital staff making its decisions about each staff member on an individual and unique basis.

Physicians are reluctant to sit in judgment on their colleagues. This attitude is understandable and there are those who believe that only the individual himself can judge his own capabilities. However, when doctors choose to associate themselves in a community effort, like that of a hospital medical staff, it necessarily follows that there must be rules and regulations and the individual becomes responsible not only for his own performance, but for that of others. He shows willingness to both judge and be judged.

Must Set Up System

To select its members and delineate privileges, the hospital medical staff should set up a system to evaluate each applicant. Except for the broad statement of principle formulated by the Board of Commissioners, the Commission cannot state what this system should be or what criteria should be used. Whatever the system, it should be objective, impartial and fair; broad enough to recognize professional excellence and limited enough to safeguard patients; and based on definite workable standards which can be easily applied.

In some hospitals a system using the classification of major, intermediary, and minor privileges is used. In others, unlimited and limited categories are established. In still others, no classification is used and the privileges of each staff member are specifically stated. If a system involving classification is used, the scope of the divisions must be well defined, and the standards which must be met by the applicant should be clearly stated for each category.

The whole problem is very basic. A credentials committee and medical staff must live up to their responsibilities and above all else have integrity. In considering any individual for staff privileges, fundamentally this question might well be asked, "Would I let this man operate on me or my family for appendicitis, read my electrocardiograms, use hypnotism on me, etc.?" If the answer is no, he should not be allowed to do so on anyone else.

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Cleveland	Cleveland Academy of Medicine 2121 Adelbert Road	CE 1-4455
Springfield	City Hospital E. High St. and Burnett Rd.	FA 3-5531, Ext. 226
Toledo	Toledo Health Department 635 N. Erie St.	CH 4-1961—(Day) GR 9-2244—(Night)

Economics Professor To Direct AMA Bureau

Dr. F. J. L. Blasingame, executive president of the American Medical Association, has announced the appointment of Arthur Kemp, professor of economics, Claremont Men's College and Claremont Graduate School, Claremont, Calif., as director of the AMA Bureau of Medical Economic Research. He took over his new duties in January, succeeding Frank G. Dickinson, Ph. D., Evanston, Ill., who is retiring after serving in the AMA position since 1946.

Born in 1916, Kemp received his Ph. D. degree from New York University in 1949. He taught at New York University from 1946 to 1953, and at Claremont from 1953 to date. Since 1943, Dr. Kemp has assisted Former President Herbert Hoover in the preparation of books, articles, statements, and addresses. Between 1946-54, he assisted Mr. Hoover in writing and preparing for publication eight books and more than 85 articles, addresses, and reports to Congress and to the President.

Dr. William F. Mitchell, Columbus, was named "Catholic Man of the Year" by the local Catholic Men's Luncheon Club. He was cited for his work in medicine, his aid in establishing the Brother Martin's Home in Columbus and for his civic and religious activities.

Radiological Society To Meet In Cincinnati, May 8-10

The Ohio State Radiological Society is having its annual meeting in Cincinnati May 8, 9, 10 at the Terrace-Hilton Hotel. The officers of this organization are: John R. Hannan, M. D., of Cleveland, president; Frances A. Miller, M. D., of Youngstown, president-elect; Francis C. Curtswiler, M. D., of Toledo, secretary; James G. Tye, M. D., of Dayton, treasurer.

An outstanding scientific session is being prepared by Benjamin Felson, M. D., Professor of Radiology, University of Cincinnati Medical School, who is program chairman. Chairman of the Committee on Local Arrangements is Chapin Hawley, M. D.

On Saturday and Sunday, April 11th and 12th, Dr. H. O. Peterson, professor and director of the Department of Radiology, University of Minnesota Medical School, will deliver the 11th Annual Joseph and Samuel Freedman Lectures in Diagnostic Radiology at the University of Cincinnati College of Medicine.

Dr. Ernest Gruening, Juneau, Alaska, became the fifth physician elected to serve in the 86th Congress. A territorial governor of the 49th state for 13 years, Dr. Gruening was elected to the U. S. Senate in the Alaska election.



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New Members of OSMA

The following are the names of the new members of the Ohio State Medical Association since December 1, 1958. The list shows the county in which they are affiliated, city in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

Allen County

Maurice L. Lewis, Lima
Thomas J. Roess, Lima

Ashland County

Vera C. Chalfant, Denbigh
John W. Coles, Jr.,
Loudonville
Paul J. Sauder, Ashland

Cuyahoga County

Samuel Cydulka, Cleveland
Richard E. Hurley, Cleveland
Ralph C. Smith, Cleveland
Joanna Sym-Lipsky,
Cleveland

Delaware County

Charles E. Ward, Delaware

Franklin County

William E. Briggs,
Columbus
Hobart R. Helman,
Columbus
Stella B. Kontras,
Columbus
Robert L. Solt, Jr.,
Columbus

Gallia County

Warren H. Pearse,
Gallipolis

Guernsey County

Howard R. Barton,
Cambridge
Basilio Gonzalez,
Cambridge

Jefferson County

Aniceto Carneiro,
Steubenville
Theodore Thoma,
Steubenville

Knox County

Richard L. Smythe,
Mt. Vernon

Montgomery County

John D. Franz, Dayton
Martha Franz, Dayton
Robert F. Lewis, Dayton
John H. Muehlstein, Dayton
John E. Osborne, Dayton
Nicholas Vasilkovs, Dayton

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* * *

The Common Cold. Discusses common cold, transmission, prevention and early treatment; also meaningless prevention and what to do about frequent colds. 5 cents. Write Government Printing Office, Division of Public Documents, Washington 25, D. C.

* * *

First Aid. Latest revision of American Red Cross handbook. Useful for physicians teaching or supervising teaching of first aid classes. 75 cents. Write American National Red Cross, Washington 25, D. C.

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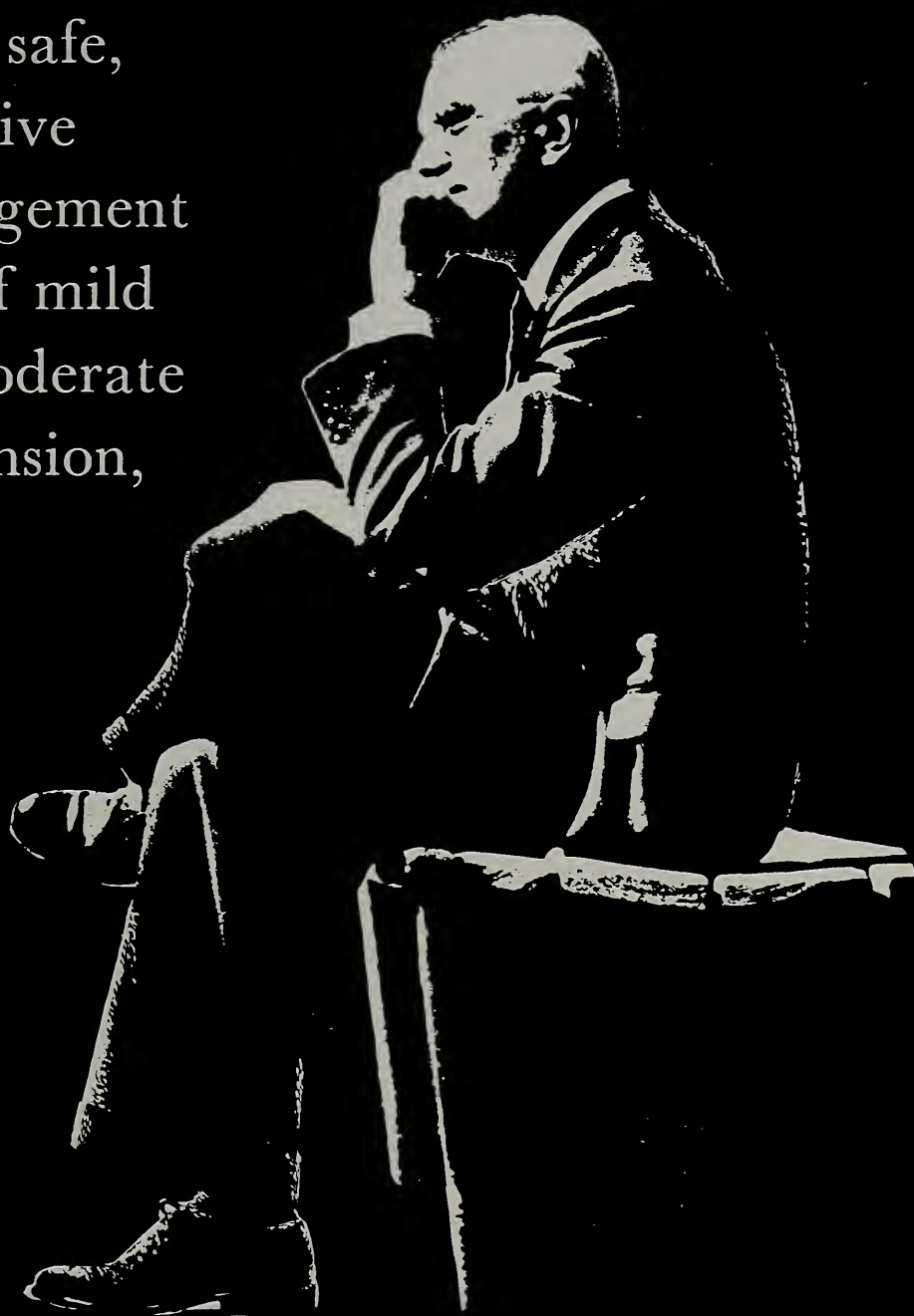
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Congress on Industrial Health Scheduled in Cincinnati

The Congress on Industrial Health is sponsoring a conference that should be of interest to a number of Ohio physicians on February 16, 17 and 18. The meeting place is the Netherland Hilton Hotel. The program has been announced as follows:

Monday, February 16

"Education and Training in Occupational Health."

2:00 p. m.—Panel; Dr. Robert A. Kehoe, Cincinnati, chairman; Undergraduate, Dr. Kehoe; Graduate, Dr. A. G. Kammer, Pittsburgh, Pa.; Postgraduate, Seward A. Miller, Ann Arbor, Michigan; Field Training, Dr. James H. Sterner, Rochester, N. Y.

7:30 p. m.—Banquet; presiding, Dr. William P. Shepard, New York City, chairman of the Council on Industrial Health; address, Dr. John D. Porterfield, Washington, D. C., Deputy Surgeon General, U. S. P. H. S.; presentation of award of the President's Committee on Employment of the Physically Handicapped.

Tuesday, February 17

"Research in Occupational Health."

9:00 a. m.—Special Topics; Dr. Sterner, chairman; Noise Problems, Kenneth C. Steward, M. S., Pittsburgh; Radiation, Conrad P. Straub, Ph. D., Cincinnati; Cancer, A. Wesley Horton, Ph. D., Cincinnati.

2:00 p. m.—Toxicology, Dr. Rutherford T. Johnstone, Los Angeles; Toxicology of Ozone, Herbert E. Stokinger, Ph. D., Cincinnati; Toxicology of Inorganic Fluorides, Dr. A. A. Brust, Cincinnati; Insecticides, Dr. Mitchell Zvon, Cincinnati.

8:00 p. m.—Joint meeting with the Academy of Medicine; address by Dr. C. W. Shilling, Washington, D. C., acting director, Division of Biology and Medicine, U. S. Atomic Energy Commission, "Everybody's Business—the Problem of Fallout and Radiation."

Wednesday, February 18

"A Phase of Practice on Occupational Medicine."

9:00 a. m.—A Clinical Conference—Presentation of cases of industrial disease by fellows and staff of the University of Cincinnati Institute of Industrial Health. Leader, Dr. Frank Princi, Cincinnati.

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Ohio State Medical Association, 1959 Annual Meeting, April 21-24, Columbus.

American Medical Association, Annual Session, Atlantic City, N. J., June 8-12.

AMA Law Department, Regional Medicolegal Conference, Hotel Cleveland, Cleveland, April 4-5.

AMA Rural Health Conference, Broadview Hotel, Wichita, Kansas, March 5-7.

Chicago Medical Society, Annual Clinical Conference, Palmer House, Chicago, March 2-5.

Congress on Industrial Health, Netherland Hilton Hotel, Cincinnati, February 16-18.

Institute on Industrial Health, and Department of Ophthalmology, University of Cincinnati, Industrial Eye Problems, March 9-12.

Northwestern Ohio Medical Association, Findlay Country Club, October 7, all-day session; registration 9:00 a.m.; first speaker, 9:45 a.m.

Ohio Orthopaedic Society, Meeting, Akron, April 10, 11.

Veterans Administration, Series of Clinical Courses, Wednesday Evenings, Cleveland.

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LICKING—Kurt J. Fleisch, President, 125 Hudson Ave., Newark; Jay Ross Wells, Secretary, 375 Granville St., Newark. Last Tuesday, monthly.

MORGAN—A. H. Whitacre, President, Chesterhill; C. E. Northrup, Secretary, McConnellsville. Called Meetings.

MUSKINGUM—J. Herbert Bain, President, 67 W. Main St., New Concord; William A. Knapp, Secretary, 1025 Maple Ave., Zanesville. 1st Tuesday, monthly.

NOBLE—Charles F. Thompson, President, Caldwell; E. G. Ditch, Secretary, Caldwell. 1st Tuesday, monthly.

PERRY—Charles E. Bope, President, Somerset; O. D. Ball, Secretary, 203 N. Main St., New Lexington. Called meetings.

WASHINGTON—William R. Stewart, President, 407 Second St., Marietta; Donald S. Williams, Secretary, 222 Third St., Marietta. 2nd Wednesday, monthly.

NINTH DISTRICT

GALLIA—Thomas W. Morgan, President, Holzer Hospital, Gallipolis; Norman W. Pinschmidt, Secretary, Gallipolis Clinic, 52 State Street, Gallipolis. 3rd Thursday, monthly.

HOCKING—George B. Watson, President, Box 296, Adelphi; Howard M. Books, Secretary, Court House, Logan. Indefinite meeting dates.

JACKSON—Tom Washam, President, 35 Vaughn St., Jackson; Brinton J. Allison, Secretary, 267 Ralph St., Jackson. Called meetings.

LAWRENCE—Gerard C. Geswein, President, 1626 S. Sixth St., Ironton; George Newton Spears, Secretary, 2213 S. Ninth St., Ironton. Monthly meetings on call.

MEIGS—Joseph J. Davis, President, Middleport; Charles J. Mullen, Secretary, Pomeroy.

PIKE—Paul H. Jones, President, Stockdale; George W. Cooper, Secretary, Piketon. 1st Tuesday, monthly.

SCIOTO—Ralph W. Lewis, President, 1025 Ninth St., Portsmouth; Carl H. Laestar, Secretary, 2829 Gallia St., Portsmouth. 2nd Monday, monthly.

VINTON—Richard E. Bullock, President, McArthur; H. D. Chamberlain, Secretary, W. Main St., McArthur.

TENTH DISTRICT

DELAWARE—Max W. Livingston, President, 28 North Vernon, Sunbury; Edward C. Jenkins, Secretary, c/o Mrs. Mabel Barrett, Jane M. Case Hospital, Delaware. 3rd Tuesday, monthly.

(Continued on Next Page)

COUNTY SOCIETIES' OFFICERS AND MEETING DATES (Continued)

FAYETTE—H. Wm. Payton, President, 36 S. Main St., Jeffersonville; Marvin H. Roszmann, Secretary, 107 N. North St., Washington C. H. 2nd Tuesday, monthly.

FRANKLIN—James L. Henry, President, 244 E. Park St., Grove City; Mr. William Webb, Executive Secretary, 79 East State Street, Columbus 15. Meetings in January, February, March, May, September, November and December.

KNOX—Henry T. Lapp, President, 4 Public Square, Mt. Vernon; Thomas L. Bogardus, Secretary, 50 Public Square, Mt. Vernon. Quarterly meetings.

MADISON—William T. Bacon, President, 40 E. First St., London; Paul G. H. Wolber, Secretary, 40 E. First St., London. 2nd Wednesday, monthly.

MORROW—Francis W. Kubbs, President, Mt. Gilead; Frank H. Sweeney, Secretary, Mt. Gilead. 1st Tuesday, monthly.

PICKAWAY—Henry H. Swope, President, 233 N. Court St., Circleville; Edward L. Montgomery, Secretary, 108 Seyfert Ave., Circleville. 1st Friday, monthly.

ROSS—Robert E. Quinn, President, 30 N. Walnut St., Chillicothe; G. Howard Wood, Secretary, 134 W. Main St., Chillicothe. 1st Thursday, monthly.

UNION—Paul R. Zaugg, President, 130 N. Maple St., Marysville; May B. Zaugg, Secretary, 130 N. Maple St., Marysville. 2nd Tuesday, monthly.

ELEVENTH DISTRICT

ASHLAND—R. Lee Schafer, President, 203 Maple Street, Ashland; Wayne C. Smith, Secretary, 140 Claremont Ave., Ashland. 1st Friday, monthly, except July, August.

ERIE—Richard F. Hoffman, President, Providence Hospital, Sandusky; Edward P. Gillette, Jr., Secretary, 410 Columbus Ave., Sandusky. Monthly meeting date varies.

HOLMES—Clyde Bahler, President, Walnut Creek; Luther W. High, Secretary, R. F. D. 4, Millersburg. 2nd Wednesday, monthly.

HURON—Walter A. Drury, President, Box 269, Willard; John V. Emery, Secretary, Box 269, Willard. 2nd Wednesday, March, June, September and December.

LORAIN—Denis A. Radefeld, President, 209 Sixth St., Lorain; Mrs. C. Ruth Zealley, Executive Secretary, 311 Elyria Block, Elyria. 2nd Tuesday, monthly.

MEDINA—Robert E. Smith, President, 403 East Liberty St., Medina; William G. Halley, Secretary, 115 Bank Street, Lodi. 3rd Thursday, monthly.

RICHLAND—Riley E. Frush, President, 36 S. Mulberry St., Mansfield; James O. Ludwig, Secretary, 336 Sturges Ave., Mansfield. 3rd Thursday, monthly.

WAYNE—Ralph I. Cottle, President, 230 N. Market St., Wooster; Robert E. Schulz, Secretary, Wooster Community Hospital, Wooster. 2nd Wednesday, monthly.

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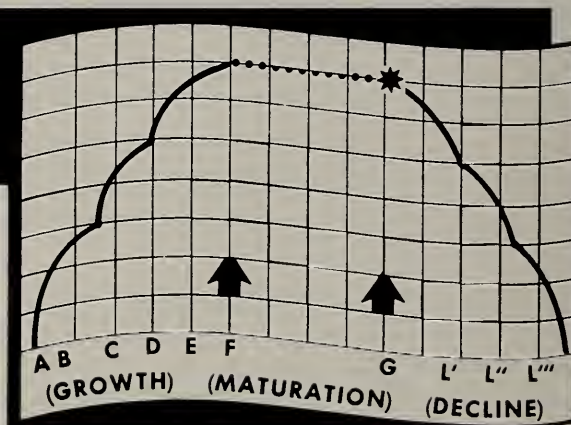
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*Chappel, C.C., J.A.M.A., 162: 1414, (Dec. 8) 1956

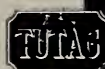
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B-12	1 mcg.	Magnesium	5 mg.
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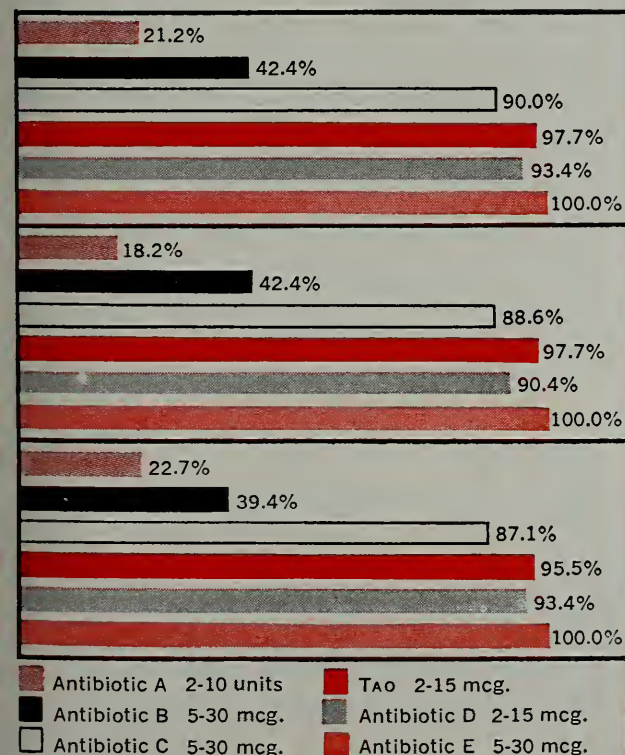
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Rapidly absorbed—stable in gastric acid,⁷ TAO needs no retarding protective coating

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Highly palatable—“practically tasteless”⁷ active ingredient in a pleasant cherry-flavored medium.

Dosage and Administration: Dosage varies according to the severity of the infection. For adults, the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. For children 8 months to 8 years, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective. Since TAO is therapeutically stable in gastric acid, it may be administered without regard to meals.

Supplied: TAO Capsules—250 mg. and 125 mg., bottles of 60. TAO for Oral Suspension—1.5 Gm., 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

References: 1. Koch, R., and Asay, L. D.: J. Pediat., in press. 2. Leming, B. H., Jr., et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 3. Mellman, et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 4. Olansky, S., and McCormick, G. E., Jr.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 5. Shubin, H., et al.: Antibiotics Annual 1957-1958, New York, N. Y., Medical Encyclopedia, Inc., 1958, p. 679. 6. Isenberg, H., and Karelitz, S.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 7. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy 5:527 (Aug.) 1958. 8. Kaplan, M. A., and Goldin, M.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 9. Truant, J. P.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958.

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For children—flavorful, easy to administer.

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To eradicate pain and physical discomfort in respiratory disorders.

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TAOMID* (TAO with triple sulfas)

For dual control of Gram-positive and Gram-negative infections.

Supplied: Tablets, bottles of 60. Oral Suspension, bottles of 60 cc.

Intramuscular or Intravenous

For direct action—in clinical emergencies.

Supplied: In 10 cc. vials.

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The Physician's Bookshelf

(Books received from publishers. *The Journal* is not obligated to list herein every book received. It will try to list those which appear to be of greatest interest.)

* * *

The Traffic in Narcotics, by Harry J. Anslinger, U. S. Commissioner of Narcotics and William F. Tompkins, U. S. Attorney for the State of New Jersey and New Jersey State Legislator. (\$4.95, *Funk and Wagnalls Company*, 153 E. 24th St., New York 10, N. Y.) An authoritative book on the drug traffic without sensationalism or exaggeration presented by experts in this field. It will appeal not only to general readers but to everyone whose professional or business life is affected by the drug traffic. Medical schools, police departments, colleges and universities, parent-teacher associations, educators, state health departments, women's clubs, the National Woman's Christian Temperance Union, students, doctors, and pharmacists will find it useful. The inclusion of a general survey of existing laws and regulations will be of value to legislators and lawyers. The development of international cooperation in the field is reviewed.

Practical Leads to Puzzling Diagnoses. by Walter C. Alvarez, M. D. (\$9.00, *J. B. Lippincott Company*, Philadelphia 5, Pa.)

Annual Report of the Surgeon General, United States Army, for the Fiscal Year 1958. (Apply, *Office of the Surgeon General, Department of the Army*, Washington, D. C.)

The Psychoanalytic Study of the Child, by Ruth S. Eissler, M. D., Anna Freud, LL. D., Heinz Hartmann, M. D., and Marianne Kris, M. D. (\$8.50, Volume 13, *International Universities Press, Inc.*, New York 11, N. Y.)

Cardiac Arrest and Resuscitation, by Hugh E. Stephenson, Jr., M. D. (\$12.00, *The C. V. Mosby Company*, St. Louis 3, Mo.)

The Relation of Human Genetics to Demography, by Jean Sutter, M. D. (25¢ *American Eugenics Society*, New York 17, N. Y.)

Changing Attitudes Toward Human Genetics and Eugenics, by Amram Scheinfeld. (25¢, *American Eugenics Society*, New York 17, N. Y.)

Vital Statistics of the United States 1956, prepared under the supervision of Halbert L. Dunn, M. D., Chief, National Office of Vital Statistics. (\$4.00, Volume 1, *Superintendent of Documents*, U. S. Government Printing Office, Washington 25, D. C.)

Centaur: Essays on the History of Medical Ideas, by Felix Marti-Ibanez, M. D. (\$6.00, *MD Publications, Inc.*, New York 22, N. Y.)

Preventive Medicine in World War II; Communicable Diseases, by Ebbe Curtis Hoff, M. D. (\$5.50, Volume IV, *Superintendent of Documents*, U. S. Government Printing Office, Washington 25, D. C.)

Paracelsus, Selected Writings: Bollingen Series XXVIII, by Jolande Jacobi, translation by Norbert Guterman. (\$5.00, second edition, distributed by *Pantheon Books, Inc.*, New York 14, New York.)

The Amphetamines; Their Actions and Uses, by Chauncey D. Leake, Ph. D., Professor of Pharmacology, Ohio State University, Columbus 10. (\$4.50, *Charles C. Thomas, Publisher*, Springfield, Illinois.)

Mental Subnormality: Biological, Psychological and Cultural Factors, by Richard L. Masland, Seymour B. Sarason, and Thomas Gladwin. (\$6.75, *Basic Books, Inc.*, New York 3, N. Y.)

Epilepsy, by Manfred Sakel, M. D. (\$5.00, *Philosophical Library, Inc.*, New York 16, N. Y.)

Clinical Obstetrics and Gynecology: Genital Cancer and Operative Obstetrics, by Daniel G. Morton, M. D., and J. Robert Willson, M. D. (\$4.50, *Paul H. Hoeber, Inc.*, Medical Book Department of Harper & Brothers, New York 16, New York.)

Clinical Obstetrics and Gynecology: Abnormal Uterine Bleeding; Special Diagnostic Aids, by John I. Brewer, M. D., and C. Paul Hodgkinson, M. D. (\$18.00, series quarterly, Vol. 1 - No. 3, *Paul B. Hoeber, Inc.*, New York 16, N. Y.)

Organized Religion and the Older Person, by Delton L. Scudder. (\$2.50, Volume 8, *University of Florida Press*, Gainesville, Florida.)

Gynecologic and Obstetric Pathology; With Clinical and Endocrine Relations, by Emil Novak, M. D., and Edmund R. Novak, M. D. (\$14.00, Fourth edition, *W. B. Saunders Co.*, Philadelphia 5, Pa.)

Progress in Psittacosis; Research and Control, by F. R. Beaudette. (\$5.00, *Rutgers University Press*, New Brunswick, N. J.)

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Washington Roundup

News from the Nation's Capital of Interest to Physicians; Developments in Medical and Health Fields

Federal Aviation Agency has decided to set up a strong medical department under medical direction, and has specified that the Office of Civil Air Surgeon shall have responsibilities for assisting the FAC administrator in setting standards, rules and regulations on fitness of flight and air control personnel, examinations, aviation medicine research, and a program of occupational medicine.

* * *

Bureau of Labor Statistics cited "higher fees for services of physicians and dentists and for group hospitalization insurance" as cause of slight increase in health care costs last two months of 1958, compared with general decline in overall living costs. Medical care is the only item in the cost-of-living index that has gone up every month since World War II.

* * *

Recently published statistics of National Health Survey shows that two out of three acute illnesses are respiratory. Period covered July 1, 1957, to June 30, 1958. The survey estimated, on basis of interviews covering 115,000 persons, that there were 438 million acute illnesses in that period, with 65 per cent being respiratory.

* * *

A \$31,165 grant to Highland View Hospital, Cleveland, was among six such awards recently approved by the Federal Hospital Council for research in hospital administration.

* * *

U. S. Tax Court, in reviewing an appeal of an Internal Revenue decision relating to an Oregon medical group, held that distribution of funds in excess of 100 per cent of physicians' base fee billings could not be ruled "ordinary and necessary expense" for income tax purposes when the affiliated physicians had agreed in writing to accept base fees as full compensation.

* * *

Public Health Service and auto industry have agreed to work closely in research on the exhaust fume problem. PHS will concentrate on health aspects while the industry seeks to develop devices to reduce fumes from exhausts. Recent National Conference on Air Pollution blamed auto exhausts for a major share of air pollution.

Civil Aeronautics Board has rejected expert medical opinion obtained by Civil Aeronautics Administration and ordered CAA to grant pilot licenses to seven men suffering from chronic illnesses, including four cases of diabetes and three cases of heart disease. The licenses, however, carry restrictive provisions.

* * *

U. S. Budget Bureau has revealed that one out of every six persons is provided all or part of his medical services by the Federal government. This represents 31 million persons, including 22.7 million veterans, 3.3 million military dependents, nearly three million servicemen, plus Indians, merchant seamen, Federal personnel, narcotics addicts, prisoners and others.

* * *

Surgeon General Burney and Francis L. Chamberlain, M. D., American Heart Association president, have jointly urged persons with diseases of the heart and blood vessels to see their family physicians about influenza vaccination, pointing out that they are particularly high risks when pulmonary infection attacks.

* * *

Civil Aeronautics Board has decreed that after July 1, command pilots of commercial airliners must have electrocardiograms included in their physicals. Noting that in recent years a number of pilots died of heart attacks in flight or just before take-off, CAB commented: "It is expected that this situation will become more frequent as the mean age of the pilot population increases."

* * *

The population of the United States reached a record high of 175,600,000 at the end of 1958, according to latest estimates.

* * *

Through the Civil Service Commission, the Federal government is attempting to recruit physicians for service in this country and abroad. Salary ranges from \$7,510 to \$12,770.

* * *

The Administration is pressing Congress to pass legislation giving the U. S. power to regulate coal tar and other colors in foods, drugs and cosmetics. One objective is to require that manufacturers demonstrate that the colors are harmless before the products can be put on the market.

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Striking clinical results with DECADRON are reported† in 92 percent of 319 patients with dermatological disorders, including cases previously unresponsive or resistant to corticosteroids. There were no major complications, and even minor side effects occurred in less than eight percent of patients.

Moreover, in many cases reactions induced by previous steroid therapy, such as edema, Cushingoid appearance, headache, vertigo, muscular weakness, depression, hirsutism, and glycosuria, disappeared during therapy with DECADRON.

†Analysis of clinical reports.

Dosage: One 0.75 mg. tablet of DECADRON will usually replace one 4 mg. tablet of methylprednisolone or triamcinolone, one 5 mg. tablet of prednisone or prednisolone, one 20 mg. tablet of hydrocortisone, or one 25 mg. tablet of cortisone.

Supplied: As 0.75 mg. and 0.5 mg. scored, pentagon-shaped tablets in bottles of 100 and 1000.

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You and Your Public

Talks to Medical Students Provide Advice Practicing Physicians Might Do Well to Review

THE Ohio State Medical Association's Annual Talks to Medical Students provide a veritable tap root of information about many aspects of the practice of medicine. These talks are delivered by practicing physicians.

All through these talks runs a spontaneous vein through which courses the constant reminder that the physician must never put aside consideration of his patient and his community—in other words, he must not ignore his personal public relations.

It is interesting to note that this thread of thought is not one agreed upon mutually by the speakers. It results from the fact that they all draw upon personal knowledge and experiences in giving their talks.

Good "Refresher Course"

While these talks are presented for the benefit of medical students, they provide a solid basis which the practicing physician, regardless of the number of years in practice, might find valuable to review as a personal PR refresher course.

Following are some comments of physicians who participated in the program for Ohio State University College of Medicine seniors on January 31.

Dr. John P. Miller, Orrville, speaking on "The Family Physician: His Practice," said, "Don't hesitate to refer your patient to a consultant when you feel it is necessary. This is good medicine. It shows that you are interested in the patient and that you have his best interests at heart."

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Dr. J. Martin Byers, Greenfield, speaking on "Meeting Medical Emergencies," said, "Have a standard operating procedure for each type of emergency. Then you are prepared to put it into action without delay as a particular type of emergency arises. Also, be prepared to 'treat' not only the patient but his whole family. In other words, you can ease the family's anxiety by reassurance."

Sell Yourself

Dr. Charles H. McMullen, Loudonville, speaking on "Economics of Medical Practice," said,

"The most important commodity you have to sell is yourself, including your knowledge and your personality. These assets you have spent all these years of your lives developing and these are what bring patients into your office. All you need to have is the physical equipment necessary to use your talents."

Dr. Jasper M. Hedges, Circleville, speaking on "Government Medical Programs Encountered in Practice," declared, "Thus, we see that there are many government programs already present in our economy, and in the years ahead there is the threat of possible government domination in medicine. Our job is to prove to the American people and to Congress that we and our allies are capable of conducting a program that is meeting, or can be expanded to meet the health needs of the people."

For the distaff side, Mrs. Victor R. Frederick, Urbana, past-president, OSMA Woman's Auxiliary, speaking on "The Physician's Wife," told the students' wives and girl friends that as a doctor's wife "you are his partner in a demanding profession. You are his public relations agent. You will find that his is a demanding profession. But you also will find that it has tremendous rewards."

Be A Good Citizen

Dr. Robert E. Reiheld, Orrville, chairman of the Committee on Rural Health, which annually sponsors the special talks, speaking on "The Physician and His Community," told the medical students, "Take an active part in your community's affairs. It's good public relations to do this. It is good for you personally and it is good for the medical profession."

OSMA President George A. Woodhouse, M. D., Pleasant Hill, speaking on "The Physician and His Medical Society," advised the future physicians:

"You should take an active interest in your local medical society because it is the first door of entrance to all of organized medicine.

"You should attend all its meetings;

"Give the local chairmen of committees your full cooperation;

"Promote the work of the society;

"Assist in its public relations program;

"Keep the Columbus Office informed concerning your own and society undertakings;

(Continued on Next Page)

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"Promptly answer correspondence received from the headquarters office;

"Attend, whenever possible, the meetings sponsored by your State Association.

"You should read *The Ohio State Medical Journal* and the OSMAGram.

"Remit your annual dues promptly to your local society secretary so your membership will not lapse.

It Depends on You

"Finally, you should remember that your local society will be just as active, alert, and effective as each individual member—meaning you. The local societies and state organization are dependent upon you and other members for support and ideas. You will get out of them what you put in them."

These speakers prepared their talks independently of one another. Yet these brief quotations from the talks show that the continuous thread of personal public relations—relations with the patient, his family, his citizens and his fellow physicians—continued unbroken from a series of talks that started at 1:30 P. M. and continued through 9 P. M.

And these quotes make a good check list by which the individual physician can re-examine periodically his own personal public relations.

Reserve Status Should Be Checked By Physicians

The National Advisory Committee to Selective Service has notified medical schools and hospitals that if any of their staff or faculty are members of the Ready Reserve, they and the individuals concerned should make note of the fact that they will be expected to go when called and not be declared essential to the institutions at the time such a call is made. If any such individuals are now in essential positions—either on faculty or staff—they should request transfer from the Ready Reserve to the Standby Reserve. By making such transfer they will, of course, lose pay. They will not lose credit toward retirement.

The committee has advised that this should be looked into at the present time and straightened out now rather than waiting for an emergency to occur. In other words, it is essential for the medical schools and the hospitals to determine the military status of the members of their faculties and staffs. In that way and only that way will they realize what their loss would be on the day an emergency is declared.

This obligation of members of the Ready Reserve to serve when called also applies to physicians in private practice. Only in very exceptional cases would such individuals be given consideration for delay due to essentiality.



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Make new Panalba*

(PANmycin† Phosphate plus ALBAmycin**)

your
broad-spectrum
antibiotic
of first resort

effective against more
than 30 common pathogens,
even including
resistant staphylococci.

Available forms:

1. Panalba Capsules, bottles of 16 and 100 capsules. Each capsule contains:

PANmycin phosphate (tetracycline phosphate complex) equivalent to tetracycline hydrochloride 250 mg.
ALBAmycin (as novobiocin sodium) 125 mg.

2. Panalba KM,†† Flavored Granules, 60 cc. size bottle. When sufficient water is added to fill the bottle, each teaspoonful (5 cc.) contains:

PANmycin (tetracycline) equivalent to tetracycline hydrochloride 125 mg.
ALBAmycin (as novobiocin calcium) 62.5 mg.
Potassium metaphosphate 100 mg.

Dosage:

Panalba Capsules. Usual adult dosage is 1 or 2 capsules 3 or 4 times a day.

Panalba KM Granules

For the treatment of moderately acute infections in infants and children, the recommended dosage is 1 teaspoonful per 15 to 20 lbs. of body weight per day, administered in 3 to 4 equal doses. Severe or prolonged infections require higher doses. Dosage for adults is 2 to 4 teaspoonfuls 3 or 4 times daily, depending on the type and severity of the infection.



In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems: Suggestions Regarding Organized Activities

JOURNAL ARTICLE PRAISED BY ELDER CO. PREXY

The Journal is running a series of articles about pharmacy, drugs, drug research, costs of research and drugs, etc. The first appeared in January; the second in February.

Mr. Thomas C. Elder, president of the Paul B. Elder Co., Bryan, manufacturers of pharmaceuticals, liked the January story, judging from the following excerpts from a letter he has written to *The Journal*:

"Thank you for the article which appeared on page 100 of the January issue of your journal.

"This is vital, because in effect it states that if a man invents a new style hoola hoop and makes a million dollars, everyone holds him up as a glorious tribute to capitalism and a free society. He represents success in our free enterprise system. If, however, the fellow is bold enough to save lives by making an original contribution to medical therapeutics in the drug industry, and incidentally, also makes a million dollars, he is a first-class S. O. B. So is the doctor who writes the prescription. So is the druggist who fills the prescription.

"A society which thus eats the meat and curses the bread will surely have all our pay checks coming from Washington unless many more articles appear of the type you printed on page 100 of your January issue. Thanks again."

The Journal hopes that others in the pharmaceutical industry will react as did Mr. Elder. Moreover, we hope that the articles will not only provide much good information for Ohio physicians but bring about a closer understanding between the two professions.

WARNING TO DOCTORS' SECRETARIES AND AIDES

Secretaries of Ohio physicians are currently being bombarded with literature from a Boston organization known as the National Registry of Medical Secretaries.

Some time ago they were asked to join an organization known as the American Registry of Doctors' Nurses.

In our opinion, Ohio secretaries should steer clear of both organizations which are purely commercial, membership-promoting projects. Neither

has the approval of the American Medical Association.

The only organization of physicians' secretaries and aides is the American Association of Medical Assistants. It has an Ohio chapter which has the endorsement of the Ohio State Medical Association.

Girls wishing to find out about joining the Ohio State Association of Medical Assistants should communicate with Mrs. Mary L. Buckley, its president, 3132 Kimball Avenue, Toledo.

DO YOU HAVE THE AMA PLAQUE ON DISPLAY?

Many Ohio physicians have placed in their waiting rooms the AMA plaque carrying this message:

"I invite you to discuss frankly with me any questions regarding my services or my fees. The best medical service is based on a friendly, mutual understanding between doctor and patient."

Are you making use of the AMA plaque? Plaques are available from the AMA at cost—\$1.00 each postpaid.

The plaque not only invites patients to ask questions, but it proves the physician displaying it has a sincere desire to bring them the best possible medical care.

A physician's office procedures should answer the patient's questions concerning fees before he asks them. A proper understanding concerning fees not only will help your physician-patient relations but also will help your collections.

Sound public relations is an economic asset in any doctor's office.

IT TAKES ACTION TO HAVE GOOD ASSISTANCE PROGRAMS

In a recent statement Dr. Gunnar Gundersen, president of the AMA, made this pertinent comment:

"Because the medical profession has accepted the principle that the provision of personal health services to the needy is primarily the responsibility of the state and local governments, it now is our duty to see that the best possible programs are developed and administered at these governmental levels."

In our opinion this constitutes a challenge to state and local public officials administering and financing health services for the needy. Such programs simply cannot be good programs if in-

1 Ladies and gentlemen:
learn all about new VITERRA PEDIATRIC,
a good supplement
in a great new package.



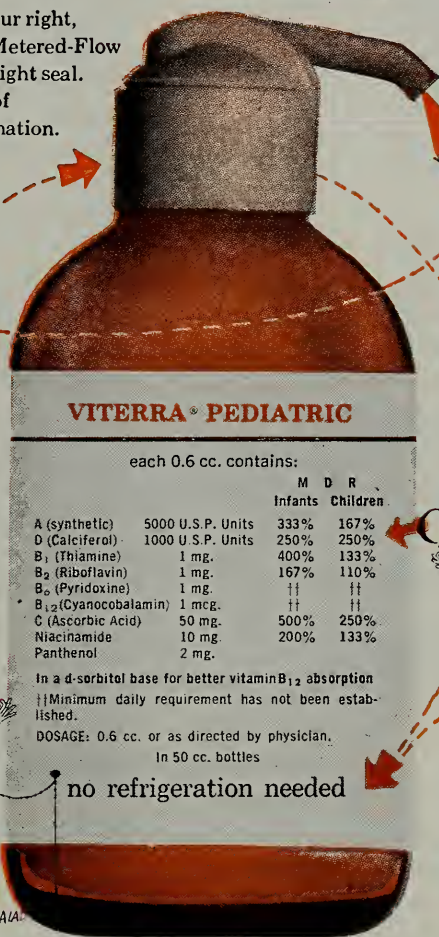
2 First,
see what happens when
you push the metered plunger.



3 Aha!
An exact 0.6 cc.
comes out this spout.
Never more, never less.

5 On your right,
see the Metered-Flow
bottle's tight seal.
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contamination.

4 And notice —
no drip, no waste,
no sticky bottle.



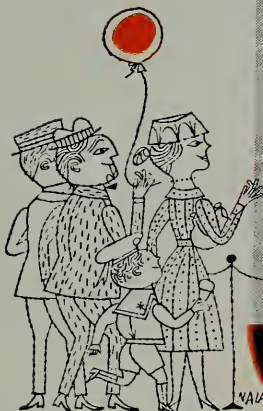
6 Let's take a minute
to admire the formula.



7 That means
no hot-weather
loss of potency.



8 Now for a farewell treat, a
taste of delicious, orange-y
VITERRA PEDIATRIC. How will
you have it — in fruit juice?
On cereal? Straight from the
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ferior personnel administers them and they are forced to try to exist on inadequate budgets.

Moreover, it constitutes a challenge to representatives of medical societies—especially County Medical Societies—as administration and financing are largely local responsibilities.

Is your County Medical Society on the ball on this? Has it checked into your local programs? Has it offered to set up an advisory committee to your local public assistance officials? If not, it's high time it took positive action.

BETTER GET A GOOD PERSONAL ATTORNEY

For years the medical profession has been advising the public: Every family needs a personal physician. Good advice, to be sure. By the same token, every physician and his family need a good "family lawyer."

The doctor at some time or other needs legal advice on personal matters; on professional problems. He should purchase legal advice to keep out of trouble; not wait to hire a lawyer after the trouble has hit.

There are a hundred and one things on which a physician can use competent legal assistance. How much better it is for him to have a personal attorney to which he can go for help at any and all times and who is familiar with his affairs, than to wait until something happens and then have to shop around for a lawyer—just any lawyer.

How about you? Got a personal lawyer?

PATIENTS HAVE A RIGHT TO KNOW

The following comment in the *AMA News* packs a lot of good sense. Experience shows that physicians who take the time to explain their fees, by and large, have better patient relations.

More physician-patient relationships have been strained by a misunderstanding about fees than perhaps any other disagreement. The first safeguard against this misunderstanding is an explanation of fees being charged.

"Some doctors feel they lack time for a frank discussion of these matters with patients, but lack of time is not a valid excuse. A patient has every right to know why he needs treatment or surgery, what it will consist of, and what it will cost—particularly where major services are to be rendered.

"For minor services, a charge slip often can give the necessary information to the patient. But even if a charge slip is used, the end of the month statement should be itemized. Too often patients for-

get how much service was rendered during the month. Thus a brief statement reading, "For professional services . . . \$75," may seem to the patient to be too high. An itemized breakdown usually will avoid this misunderstanding.

"If a statement is not itemized, it should at least have these words printed at the bottom of the statement, "Itemized statement on request."

"It is also important that a physician's secretary be apprised of the various items included in a patient's statement. The secretary should be able to explain fees so the patient understands completely before leaving the office.

"Generally the patient's reaction to a fee is determined more by the doctor-patient relationship than by the size of the fee, itself, or by the quality of medical care given."

COMPULSORY GIVING IS OUT OF ORDER

Just to refresh the memory of physicians—and others—here is the current policy of the American Medical Association (and a good one, in our opinion) on contributions by physicians to hospital building funds:

"Neither the medical staff or hospital management has the privilege or the right to make compulsory assessments of members of the medical staff for building funds or to demand a record of staff members personal financial records as a requisite for staff appointment."

COURSE IN JOURNALISM FOR DOCTORS — A FINE IDEA

The Department of Journalism and the College of Medicine at Ohio State University are cooperating on a project which should produce some good results.

A special section of journalism 602 (magazine writing) is being devoted exclusively to medical people and their writing problems. Any of the medical personnel may register for the course.

The program is designed to develop more effective techniques in professional writing and make the job of writing easier for physicians.

Obviously, anything which will provide an opportunity for physicians in training or in practice to improve their writing techniques should be encouraged. Too few physicians even make the effort to contribute to medical literature. Unfortunately, too small a percentage of those who do, are able to turn out copy which is interesting, concise and understandable.

Be a good idea if other medical schools would seek a similar hookup with some journalism school.

easier swallowing after T & A



Xylocaine Viscous provides quick-acting and prolonged surface anesthesia for sore and painful throats, particularly those occurring after tonsillectomy and adenoidectomy. Its cherry-flavored, water-soluble vehicle spreads evenly and adheres intimately to the membranes. Nonirritating and nonsensitizing. Dose: 1 teaspoonful, swished around in the mouth and then swallowed slowly.

Write for additional information regarding other uses which include management of hiccup and reflex vomiting, as well as relief of discomfort associated with laryngoscopy, esophagoscopy, gastroscopy and the passage of esophageal and gastric tubes.



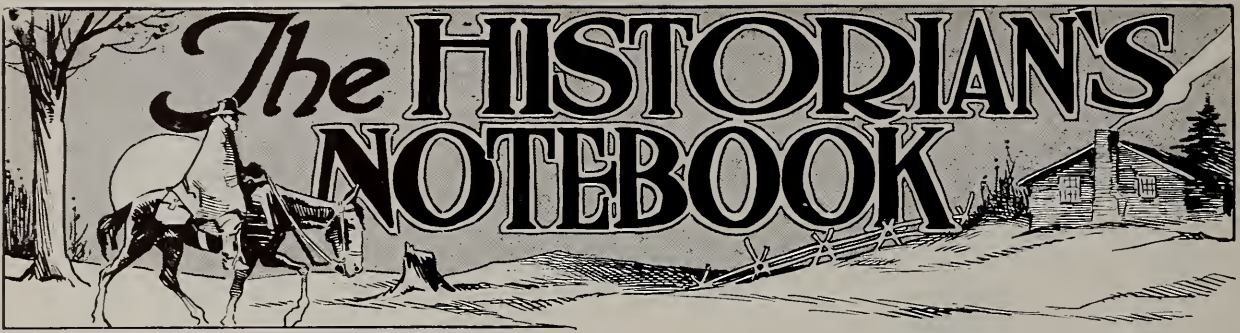
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U. S. Army Medical Service Contributions To Civilian Health and Medicine

IN 1893 Surgeon General George M. Sternberg established the U. S. Army Medical School (now known as the Walter Reed Army Institute of Research) which has been called "America's oldest school of preventive medicine." Sternberg had done laboratory work on yellow fever, and it was he who selected Walter Reed to head the famous Board set up to study the malady. Sternberg was also the author of the first American textbook on bacteriology and, as a pioneer in photomicrography, was the first to photograph the tubercle bacillus.

Some of the first roentgenograms taken in this country were taken at the Army Medical Museum in 1896, some six months after Röntgen announced his discovery. Much of the pioneer work with x-ray was done in the Army, especially during the Spanish-American war.

Operation Mosquito Bar

Malaria has always been a disease of great interest to medical officers of all armies. The discovery of the parasite of malaria by the French medical officer Charles L. Laveran in 1880, while serving with the French Army in Algeria, remained largely unknown until 1886, when it was brought before the medical profession of the United States by Army Surgeon (later Surgeon General) George M. Sternberg. In 1897 British Army Maj. Ronald Ross of the Indian Medical Service demonstrated the mosquito as the vector of malaria, and devised methods for the destruction of mosquitoes.

American Army medical officers did not lag in antimalarial work, Maj. (later Brig. Gen.) Jefferson R. Kean in 1898 being the first to recommend the use of the mosquito bar by troops not only as an aid to comfort, but also as an antimalarial measure.

Until World War II quinine was the drug of

● This is the second of a series of articles about the contributions of the United States Army Medical Service to civilian health and medicine. Article No. 1 appeared in the February issue and No. 3 will be published in April. The material was compiled by the Office of the Surgeon General, Technical Liaison Office, Washington, D. C., and released in July, 1957.

choice for malaria. Beginning in 1942 numerous American investigators tested some 15,000 compounds for antimalarial effectiveness, and by the summer of 1952 had developed a new drug called primaquine.

The Army proved the effectiveness of primaquine, the first successful cure for malaria, when it administered the drug to all servicemen returning from Korea by water. There is every indication that the use of this drug—and chloroquine as a suppressant—has eliminated malaria as a major medical problem.

Maj. Walter Reed demonstrated the mode of transmission of yellow fever shortly after the Spanish-American War, and Col. (later Maj. Gen. and Surgeon General) William Gorgas drove the disease from Panama, thus making possible the construction of the Canal. Until 1900 yellow fever had been an enemy not only of the Army but of the country as a whole. The last epidemic in the United States was in 1905, the last naturally occurring death from this disease in the United States was in 1924. There were no cases of yellow fever among our troops in World War II or in the Korean War.

At the conclusion of the Spanish-American War Lt. (later Col.) Bailey Ashford studied what appeared to be an epidemic of pernicious anemia in



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Improve appetite and energy

with ample amounts of vitamins—B₁, B₆, B₁₂.

strengthen bodies with needed protein

Through the action of L-Lysine, cereal and other low-grade protein foods are up-graded to maximum growth potential.

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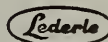
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Each teaspoonful (5 cc.) contains:

L-Lysine HCl	300 mg.
Vitamin B ₁₂ Crystalline	25 mcgm.
Thiamine HCl (B ₁)	10 mg.
Pyridoxine HCl (B ₆)	5 mg.
Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
Sorbitol	3.5 Gm.

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Puerto Rico, a scourge to its agricultural workers. He discovered that the disease was due to hookworm. As a result of his recommendations a campaign for treating the inhabitants was begun. Its success led to the duplication of his work in the Southern United States, through the efforts of the Sanitary Commission of the Rockefeller Foundation. Today hookworm is no longer an important public health problem in the United States.

Three Tropical Disease Boards were established by the Army Medical Service in the Philippine Islands—in 1900, 1906, and 1922. The primary responsibility of the Boards was the study and control of tropical diseases. The mosquito theory of dengue fever transmission was confirmed by Col. Joseph F. Siler, a Board member. The men working under the auspices of these Boards discovered new species of filaria and of malaria, and determined the amoebicidal properties of emetine, which resulted in the drug being established specific for amoebic dysentery. They found that beriberi was caused by eating polished or milled rice, and that eating unpolished rice prevented the occurrence of the disease.

Rice Gives a Cue

This discovery led to the prevention of much suffering and many deaths among the rice-eating people of the earth, and led to further scientific work on vitamins. Col. E. B. Vedder was a pioneer in these investigations. United States Army medical officers contributed greatly to what has been called "The Golden Age of Tropical Medicine in the United States"—the first 20 years of this century.

Another outstanding contribution of the Army Medical Service was the conquest of typhoid fever. In 1908 Maj. Frederick Russell of the Army Medical Corps submitted a report on the epidemiology of typhoid fever, the devastating effects of which he had studied in foreign armies. This led to the adoption of compulsory anti-typhoid vaccination in the United States Army, with successful results. The Army was the first organization to use typhoid vaccination in the United States on a large scale.

In 1910 Maj. (later Brig. Gen.) Carl R. Darnall of the Army Medical Service originated the use of liquid chlorine to purify water. The method has been adopted throughout the world and by reducing typhoid fever and other waterborne diseases has probably saved as many lives as any other medical achievement.

There were only 50 cases of typhoid in this country last year, despite a low level of vaccination among the civilian population. Thanks to the combination of typhoid fever vaccination and

chlorinated water, there were less than 100 cases of typhoid-paratyphoid fever among United States troops during three years of the Korean conflict, despite widespread water pollution and other highly unsanitary conditions.

Captains (later Colonels) Ernest R. Gentry and Thomas L. Ferenbaugh in 1911 showed that Malta fever was endemic in our Southwest. Gentry also did good work in the closely related bacillus abortus infection.

In 1912 Maj. (later Brig. Gen.) Edward L. Munson, as president of the Army Shoe Board, devised the Munson last for Army shoes. It was adopted by the Army, and, later, by many shoe manufacturers for civilian use.

Photographs TB Bacillus

Many officers of the Army Medical Service have made outstanding contributions to the country's knowledge of tuberculosis. Surgeon General Sternberg was the first to photograph the tubercle bacillus, and Col. George E. Bushnell in 1913 brought out the importance of good hygiene in the prevention of tuberculosis.

Another leader in the fight against tuberculosis in this country was Maj. Gen. Charles R. Reynolds, who retired as Surgeon General in 1939. After retiring from the Army he organized the Bureau of Tuberculosis Control of the Commonwealth of Pennsylvania and had charge of numerous tuberculosis clinics throughout the state. General Reynolds pioneered state-wide x-ray examinations for all clinic patients. Col. William H. Richardson, his assistant in this work, was also a retired officer of the Army Medical Service.

After Selman Waksman and his associates discovered streptomycin in 1944 the Army, Navy and Veterans Administration pioneered in the use of streptomycin for tuberculosis. The highest proportion of tuberculosis cures in history is being achieved through the use of this drug, in conjunction with other drugs recently developed.

During World War I the American Red Cross established a medical research committee to investigate an acute communicable disease not unlike typhus fever, which the British called "trench fever." A former Regular Army officer, Col. Richard P. Strong, directed the committee, which found that the disease was louse borne—an agent related to that causing typhus fever.

Based on his experiences with the British and American Expeditionary Forces in World War I, Col. Hiram W. Orr proposed the "closed treatment" for compound fractures. His method of treatment had its actual war test in the Civil War in Spain, and was vindicated.

(To Be Concluded in the April Issue)

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R. GORDON MOORE,
Asst. Managing Editor

A New Look at Emphysema

F. L. MENDEZ, JR., M. D., and ELMER R. MAURER, M. D.

Introduction

IN the light of the recent medical advances, our knowledge and treatment of pulmonary emphysema appears shabby indeed! At a time when we find available the necessary devices and drugs with which to aid such patients, our thinking has become stereotyped. All too often the emphysematous patient appears as the pathetic, wheezing, chain-smoking individual, who weekly finds only a chair in our waiting rooms. Realizing, all too frequently, that we have been of little help to these patients, we are naturally reluctant to give them the thought and time so necessary to their well-being. As a result of such forces, these people gravitate into the hands of poorly trained "professionals" or become the victims of pharmaceutical fads.

As our population increases in its average age, this problem will become more definitive and as our civilization evolves more and more pulmonary irritants, emphysema will continue to increase. Alarming as the situation concerning pulmonary neoplasm has become, the number of individuals afflicted is small when compared with those suffering from some phase of pulmonary emphysema. We cannot believe that it is normal pulmonary physiology for our elderly citizens to spend days and nights in paroxysms of cough and dyspnea. Therefore, it becomes the responsibility, if not the duty, of each practitioner of medicine to review

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our knowledge and mode of treatment of this incapacitating pulmonary disease.

Pathogenesis

Semantically speaking the medical term, *emphysema*, is derived from the Greek language and means "to inflate." Etiologically the derivation of the term would indicate a "blowing up" of the pulmonary tissue. We believe sufficient data have now accumulated to indicate that the primary pathogenesis is in the bronchiole tree and not in the pulmonary parenchyma. What we so dramatically see at the postmortem table is the end result of the process and not the pathogenesis. In our opinion, the pathogenesis of pulmonary emphysema follows closely that set forth by Abbott et al.¹

The causative agents, which ultimately bring about the destruction of the alveolar spaces, first

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affect the bronchioles. Others have pointed up the underlying allergic substratum. Superimposed upon this fertile ground, the irritants of everyday living coupled with the Twentieth Century habit of tobacco smoking produces bronchiolar irritability. Symptomatically this appears as the cough and wheeze, or what our modern language chooses to call "cigarette cough." Over a varying period of time, differing in individuals with different tissue backgrounds, the bronchiole irritation converts into intermittent bronchiolospasm.

With the development of bronchiolospasm, we need but continue the irritation over a sufficient period of time to produce the early changes of parenchymal pathology. Since the tussal power of the human animal is of a high magnitude, obstruction of the bronchioles by the described mechanism produces in essence, an obstructive type of respiration. Campbell² et al. calculated the intraluminal and peribronchial pressures. They found that with bronchiolospasm the peribronchial pressure was sufficient to produce bronchiolar occlusion on the expiratory phase. When such a phenomenon occurs over a sufficient period of time, alveolar distention results.

With the occurrence of constant or intermittent bronchospasm, secretions are trapped behind the narrowed bronchioles. The ciliary action can no longer complete the assigned task, namely that of "policing the bronchiole passages." Next is added the bacterial agent. With bronchiostasis and retained secretions the organisms find a most receptive media for expansion. Many patients will attest to this fact when questioned as to the effect of the antibiotics. Somewhere in their pilgrimage, these patients have been given antibiotics and with dramatic results. However, the treatment as a rule was inadequate and no attempt was made to remove the causative agent. Thus, the antibiotic effect was only a temporary one. With the addition of infection, bronchiole irritation, bronchial edema and peribronchial pneumonitis occur. Thus, the stage is properly set for this development of "inflated" pulmonary tissues, only time need be added.

The hallmark of pulmonary emphysema is that of an increasing residual air space. With the present-day techniques we can measure the residual air space and thus obtain some degree of scientific information. The accepted normal for residual to total air space is in the neighborhood of 25 per cent. Since our pulmonary system has enormous reserve capacity, early changes in residual to total air are not appreciated by symptoms or signs. Therefore, the patient continues to follow the course which, with the passage of sufficient

time, will ultimately produce the far advanced syndrome we choose to call pulmonary emphysema.

Pulmonary function studies represent reliable, reproducible data when carried out with certain strict precautions as to the equipment and the operating personnel. It is indeed unfortunate that in an era of "laboratory" medicine, we have so poorly received these standards which measure a most vital function. Most physicians are cognizant of the various tests designed to assay hepatic function, yet few are willing to investigate or utilize the measurements available for the pulmonary system.

Being able to measure and record data in a scientific manner brings useful information. Such studies have been carried out on the relationship of bronchospasm to pulmonary function. These studies clearly indicate that the primary pathophysiology is one of obstructive respiration and can be readily relieved by the treatment of the bronchiolospasm. Armed with such physiological facts, we readily realize that emphysema is nothing more than a term applied to the parenchymal changes of chronic intermittent bronchiolospasm.

For the sake of discussion only, we find it advantageous to classify emphysema into several groups. Since the parenchymatous changes may be localized or general in character, it is of importance that we understand what is being alluded to. Thus the term *emphysema* is certainly a poor one and much too inclusive in character. We would favor the use of a more descriptive term, such as Abbott et al.¹ propose, namely *Progressive Obstructive Pulmonary Atrophy*. This can then be subdivided into localized or general forms and graded to include certain types for each category. Since any classification is a purely artificial device we will expect to find patients who defy accurate cataloguing.

As yet we have made no mention of the effect of alveolar distention upon the remaining systems in the pulmonary tissue. Certainly we must consider the vascular and lymphatic systems. The prolonged alveolar hypertension caused by chronic intermittent bronchiolospasm results in changes in the alveolar septa. This produces a dramatic effect upon the pulmonary capillary and lymphatic channels. With increasing alveolar pressure, pulmonary capillary pressure must perforce rise. This in turn is reflected in the elevated pulmonary arterial pressure so commonly found in the far advanced emphysematous patient. Volumes have been written concerning cor pulmonale to attest to this intimate relationship. As the pulmonary capillaries are slowly closed off, nutrition to the alveolar septa fails and tissue destruction occurs. Septa dis-

appear and in time bullae may replace the destroyed or atrophic pulmonary parenchyma.

The preceding story sets forth the pathogenesis of progressive pulmonary atrophy and fixes the underlying cause upon the chronic intermittent bronchiole obstruction. It can serve no useful purpose to delve into the details of the symptoms or signs associated with this disease. Many books and more articles have been published which adequately contain such knowledge. However, we feel that it is of the utmost importance that the overall picture is in focus. The symptoms and signs will vary from patient to patient, depending upon the stage and the type of disease present. Likewise the addition of complications such as bronchiectasis, pneumothorax, cor pulmonale, etc. all create additional confusing signs and symptoms. The underlying patho-physiology remains the same — chronic intermittent bronchiolospasm with bronchiolostasis and infection.

Treatment

Our intentions here are mainly to (1) incite a renewed interest in progressive obstructive pulmonary atrophy (emphysema), (2) to outline what we feel is a program of energetic treatment, and (3) to set forth a new method of therapy. Ideally the treatment of this condition is one of *prophylaxis*. We do not deny that many individuals may smoke without apparent pathological reaction. We know also that some 40 to 45 per cent of those suffering from pulmonary emphysema have a family history suggestive of an irritable bronchiole tree. Likewise, we are certain that 99 per cent of those afflicted with pulmonary emphysema have at some time indulged heavily and for long periods in the use of tobacco. Thus, it is obvious that tobacco smoke plays an important role as a bronchiole irritant in this group.³

We realize that there are about us other known and unknown bronchiole irritants. Anyone who has followed our commercial transports about our cities will realize this fact. Yet the one factor we can control and most frequently do not is that of tobacco usage.

Regardless of the moral right or wrong of the tobacco "habit," we decry its usage because of bronchiole irritation. Tobacco usage creates other problems which have been well documented. Being unable to accomplish our designed aim by prophylaxis, we must be prepared to outline a regime that will overcome the patient's problem.

(A) Therapeutic Regime:

Since we see various stages of the disease along with various complications, it is vital that we attack the early changes with vigor. For our personal

use we attempt to make a thorough study of the patients before initiating such a program. For this purpose we prefer hospital observation for from 10 days to two weeks. However, in certain selected cases we will attempt outpatient therapy.

Upon admission to the hospital we carry out the following studies:

(1) Complete history with special reference to pulmonary background, industrial exposure, pulmonary diseases, social history, and a complete and thorough physical examination.

(2) Chest fluoroscopy and appropriate x-ray studies. We believe it is of the utmost importance that the physician responsible for the patient either do the fluoroscopy or be present when it is done. It is necessary to search for unequal air distribution, air trapping, cardiac size, diaphragmatic motion, and "jump back" sign.

(3) Laboratory studies. If the facilities are available the $p\text{CO}_2$, $p\text{O}_2$ and the pH determinations would be of distinct value. These are not difficult studies and we should not continue to allow our laboratories to neglect them.

(4) Pulmonary function studies to include timed vital capacity and residual air. However, the entire series should be carried out. We realize that these facilities are not readily available in all communities and thus would delay these studies until later if necessary. At some time in the course of the patient's study, pulmonary function analysis is essential.

Following this preliminary diagnostic study the patient is scheduled for a bronchoscopy. This procedure will serve two vital functions. *Diagnostically*, the bronchoscopy will enable the physician to view the bronchi and to analyze the amount and severity of the inflammatory changes and bronchospasm. *Therapeutically* it will result in a "washing out" of the bronchiole secretions and produce temporary bronchiole dilatation. This aspiration bronchoscopy is of the utmost importance and occasionally will need to be repeated several times during the early phases of therapy. It is important that the physician either carry out the bronchoscopy or be present at the time in order to evaluate the factors of infection and spasm.

Following bronchoscopy we frequently have the patient save all sputa for the next 24 hours. Usually the bottle will be filled with gray to yellow secretions before the 24 hour period is up. The patients volunteer the evidence of increased respiratory depth. The material obtained at the time of bronchoscopy is sent to the laboratory for routine studies which include (1) smear, culture and guinea pig inoculation for tuberculosis bacilli,

(2) smear and culture for fungi, (3) culture and antibiotic sensitivity studies to the bacterial flora and (4) cellular studies for the possibility of malignancy.

With such information on hand the patient is placed in the appropriate classification. This is done in order to simplify maintenance of records and to study these groups as distinct entities. Such study of these individual groups often leads to additional information concerning the disease as a whole. However, it is important that one does not lose sight of the fact that this classification is purely artificial. Progressive obstructive pulmonary atrophy is a relentless process involving considerable time and reflecting a changing clinical picture.

Therapy is designed to treat the underlying patho-physiological changes, namely that of chronic intermittent bronchiolospasm and infection. Therefore, the first step is to remove so far as possible all irritants. **Smoking is forbidden**³ and unless the patients will cooperate in this we request that they seek advice elsewhere. Fortunately, by the time these patients reach this state they have become convinced of the irritant properties of tobacco. Thus, we have had no great problem in getting across to them the importance of total abstinence from tobacco. Their presence in the hospital, likewise, reduces irritation from other sources such as jobs, home, etc.

Lateral chest exercises are introduced and the patient is properly instructed in their function and use. Emphasis is placed on these simple techniques. Since bronchiole ciliary action is lacking or very poor, we utilize these exercises to increase the expectoration of secretions. In one sense the exercises replace by the air flow velocity what the cilia are no longer able to accomplish. We insist that the exercises be carried out three to four times daily and with vigor. Later this is reduced to morning and evening and carried on for a prolonged period. The exercises, in addition to relieving trapped secretions, also aid to building up the power of the respiratory machine. In certain cases, diaphragmatic exercises are added to increase, if possible, the diaphragmatic excursions. Any increase in the diaphragmatic excursions, however slight, will considerably increase tidal volume and aid the efficiency of the pulmonary exchange. We cannot overemphasize the value of these simple exercises and would give up the medication before discontinuing these adjunct respiratory aids.

Secondarily the program of treatment is directed at overcoming the bronchial infection. We select a broad spectrum antibiotic and utilize it in high dosage. The more specific antibiotics such as penicillin are of value in the early cases. However, our patients have usually had several such

courses and the bacteria have become resistant. Ideally, of course, the antibiotic should be selected from the sensitivity studies. This, however, will necessitate some delay and practically we find such reports usually point to the broad spectrum type of drug.

A second factor concerning the antibiotic program is often overlooked. *Prolonged use is necessary*. A minimum of three weeks is essential. Many patients will require an additional course of antibiotics following an acute respiratory infection. It is important that the drugs selected be utilized fully and then terminated so as to avoid the development of bacterial resistance. We cannot predict how much longer our pharmaceutical houses will be able to keep ahead of the bacterial flora.

Although several authors have suggested that aerosol therapy was of little value, our experiences certainly indicate otherwise. Primarily we utilize the aerosol technique to overcome bronchiolospasm. This is accomplished by the proper nebulization of one of the potent smooth muscle relaxants such as isoproterenol hydrochloride, Adrenalin,[®] etc. Nebulization is carried out three to four times daily. Since these drugs are of short duration in their action, such repeated nebulizations are necessary. In addition, an antibiotic is added to aid in overcoming the bronchial infection. At present there are available only two to three suitable antibiotics which can be satisfactorily nebulized.

Care must be taken to prevent irritation of the oropharyngeal membranes and the secondary development of fungi infestation. While hospitalized the use of aerosol with oxygen is a simple matter. In the home it requires some type of air power. In our experience, electric pumps have been prohibitive in cost and poorly designed for the purpose. Therefore at present, we suggest the use of an inexpensive auto-foot pump. In some cases the investment in an electric pump of the correct type is essential.

It should be pointed out that merely writing the order for aerosol will not accomplish the desired result. The physician must check the nebulizer for function as all too often we find them broken, clogged or ineffective. Unless the "fog" produced is adequate, the treatment is wasted. Aerosol therapy is usually continued for a week to 10 days. In the home, it may become necessary for the patient to resort to aerosol one week in the month. Such a routine is flexible and can be determined by the character and amount of sputum expectorated. After short experience, these patients learn to read such signs of infection and can be relied upon to instigate aerosol when necessary.

Expectorants are utilized to thin the secretions

and to increase the amount. By such method we aim at "washing out" the tenacious mucoid secretions so characteristic of emphysema. Our preference at present is for one of the readily available liquid expectorants in conjunction with saturated solution of potassium iodide. Dosages, however, are maximum and must be so to be effective. Approximately 8 cu. cm. of the expectorant and 15 drops of the saturated solution of potassium iodide are given four times daily. Such medications must be carefully observed, since patients will develop local or generalized reaction to these drugs. With evidence indicating a hypersensitive substratum, we introduce one of the long acting antihistamines. In many cases these are of a distinct advantage.

It is paramount that cough sedation not be attempted unless considerable fatigue has occurred. Suppression of the cough mechanism is counter to all of the efforts being used to remove the bronchial secretions and to control infection. Therefore, we forbid the use of such drugs unless a specific instance requires them. Narcotics that delay or allay cough are contraindicated.

In the early period of treatment of progressive obstructive pulmonary atrophy, it may be difficult to control bronchiolospasm. Unless bronchiolospasm can be relieved, little success can be expected from any therapy. Therefore, in these cases, usually that of far advanced disease, we will resort to intravenous drugs for bronchiole-dilatation. Aminophyllin is a valuable bronchiole-dilator, when given intravenously. Sodium iodide can increase bronchiole secretions significantly. These drugs are combined in an intravenous drip and given slowly. It is important that the solution be given over a 10 to 12 hour period. This will maintain bronchiol-dilatation and prevent the gastric upset so frequent with the use of aminophyllin. Unless this technique is followed, the patient will be made worse by the nausea and vomiting which will ensue.

In the stubborn cases of bronchiolospasm, we have resorted to intravenous meperidine hydrochloride with success. This drug can be given intravenously in sufficient dosage to effect bronchial relaxation and the relief of anxiety. Therefore, in selected cases we find this drug of value when properly given. We look forward to the day when a potent bronchial-dilator will be available which can be used orally and will have a prolonged action.

Up to this point, we have avoided the use of oxygen, since many of these cases, particularly the far advanced ones, have adjusted to a mild respiratory anoxia. The injudicious use of oxygen may precipitate apnea. The respiratory mechanism is

driven essentially by the CO_2 level. These patients in the advanced stages of the disease have adjusted to an elevated pCO_2 level. This can readily be measured or may be suspected by the abnormal red blood cell count or hemoglobin levels reported on the hospital chart. The use of oxygen lowers the pCO_2 and produces apnea. Such a situation becomes critical as each bout of intermittent respiration begins to alter the buffering systems and eventually produces a pH shift. For these reasons unless the situation is clear or a desperate demand is present, we avoid the use of oxygen for prolonged periods. When nebulization for aerosol therapy is necessary in such cases, we use compressed air to produce the aerosol.

Of course, attention must be paid to the details of other systems. Nutrition in these patients is poor. After a short term of treatment and because of discontinuation of tobacco, most patients begin to improve their dietary intake. In the advanced stages of progressive obstructive pulmonary atrophy, hepatic function is often compromised. Attention to the cardiac mechanism is of the utmost importance. However, once the bronchiolospasm and infection is overcome, the pulmonary artery pressure may decline and the right heart again become compensated. It is useless to treat the right heart in the face of pulmonary disease without vigorously attacking the bronchiolospasm and infection.

The program we have outlined above must be carried out with vigor on the part of the patient and attention to detail on the part of the physician. These patients must be made to understand that their hospital stay has just started them on the way to improvement. At home they must continue to follow faithfully their regime or in a short time the situation will again reach its previous state. After three to four weeks and judging by the presence or absence of infection and bronchiolospasm, we begin to remove some of the artificial supports. The antibiotic is discontinued and the patient observed for several weeks.

One must constantly admonish these patients to carry out the simple but effective exercises. We inform these patients that these exercises will become a necessary way of life for them. The expectorants can be decreased gradually and if no contraindications are present, these drugs are discontinued. Return to employment, if tolerated, is allowed early. The aim of the physician and the patient should be towards the removal of irritants insofar as possible, discrimination of medications and care of the bronchial toilet by simple exercises.

On occasions and in the presence of active respiratory infection it may be necessary to return to aggressive therapy for another three or four

weeks. By careful follow-up and adequate patient instructions these periods can be passed through with a minimal amount of disruption to the patient's normal routine.

(B) Surgical Therapy:

Having faithfully carried out such a program, there will remain a group of patients with bilateral moderately advanced disease that require some type of additional therapy. It is with this group that we have searched and continue to do so, for some permanent form of therapy. The problem, as always, is that of bronchiolospasm and of a high residual air. Infection can be controlled and exercises will increase to some degree the respiratory mechanics. However, these patients remain moderately incapacitated and become depressed as to their "gasping future."

Our experiences would indicate that pulmonary vagotomy will release the chronic bronchiolospasm and allow increase in pulmonary function. We feel that the basic pathology is one of "overplay" of the parasympathetic system to the bronchiole musculature and mucosa. This results in an obstructive respiratory mechanism and ultimately to progressive pulmonary atrophy. We feel that some such vigorous approach is necessary wherein the group of patients have been failed by all conservative managements.

Once maximum improvement is obtained in the chronic bronchiolospasm group, we subject these patients to intensive investigation. This includes complete pulmonary function studies. Following these studies we carry out blockade of the parasympathetic systems at the cervical level after the technique of Dimitrov-Szolsode et al.⁴ When evidence indicates an effective blockade, the pulmonary function studies are repeated.

Should the blockade studies indicate complete relief of bronchiolospasm and improvement in the function studies, we recommend study of the pulmonary arterial system by right heart catheterization. The pulmonary artery pressure is measured at rest and again following exercise with particular attention to the height of elevation and time of its return to the baseline. Likewise, the use of bronchodilators and their effect upon the pulmonary artery pressure is investigated. If these studies indicate a pliable pulmonary resistance, we feel that pulmonary denervation is in order.

In this selected group, we recommend vagotomy of the bronchial plexus.⁵ This is carried out in stages and requires resection of the vagus nerve from a level just below the recurrent laryngeal. Since the vagus fibers interlace and cross the midline it is of the utmost importance that the bilateral denervation be carried out completely. At

each stage bronchial paralysis will be evident and require postoperative bronchoscopy on several occasions for cleansing purposes. Gradually, however, the bronchus is again able to care for its own secretions.

During such surgery and postoperatively, the regime for the control of infection and the pulmonary exercises must be rigidly adhered to. It is to be emphasized that such surgery in this selected group is an *adjunct* procedure and by itself cannot effect improvement. To attempt such surgery in the poorly selected case and without adequate preparation is to condemn the approach and to compromise the patient. In those who refuse to abstain from the use of tobacco, we feel that the operation should definitely be withheld.

Results

Figure 1 gives the data taken from one of our cases. Pulmonary function studies were carried out after initial treatment for progressive obstructive pulmonary atrophy of a diffuse nature with considerable infection. The 1956 studies indicate considerable compromise of the pulmonary ap-

PULMONARY FUNCTION				
	5/4/56	4/24/57		2/6/58
Respiratory Rate (min.)	33	Preblockade	Postblock.	Postop.
MBC (liters/min.)	42	37	—	90
Vital Capacity (cc)	1,165	1,030	2,150	2,460
Inspiratory Capacity (cc)	245	549	1,820	1,450
Expiratory Reserve Vol(cc)	269	558	968	1,070
Tidal Volume (cc)	220	296	484	400
Minute Volume (liter/min)	7.2	11.2	13.6	8

FIG. 1. Pulmonary function studies obtained during various phases of study and postoperatively. The 1956 figures were obtained after the infection and bronchiolospasm had been treated. Note the similarity to the pre-blockade figures. Postblockade figures indicate considerable ventilatory improvement. Respiratory rate decreased while function improved. Postoperative figures indicate a good result was obtained.

TIMED VITAL CAPACITY				
	5/4/56	4/24/57		2/6/58
		Pre-blockade	Post-blockade	Post-operative
1 st. second	—	240 cc	750 cc	470 cc
2nd second	—	350 cc	1750 cc	970 cc
3rd second	—	620 cc	2250 cc	1470 cc

FIG. 2. Comparison of the timed vital capacity figures at the time of vagal blockade and those obtained postoperatively. Note the improvement at the time of blockade. Postoperative figures indicate considerable increase in the ventilatory function.

paratus while bronchiolspasm and infection were present. After prolonged therapy, these studies were repeated before and after autonomic blockade. The character of improvement is obvious. In this instance the right heart catheterization revealed a changing pulmonary arteriolar resistance. Thus, total pulmonary parasympathetic denervation was carried out in stages. Upon adequate recovery, the function studies were again repeated. At this time no bronchiolspasm was clinically

evident. Again the studies reflect marked respiratory improvement.

Figure 2 dramatically brings out these changes when comparing the timed vital capacity, pre-blockade, postblockade and postoperative. Such a study measures the amount of obstruction present to the expiratory phase and reflects the severity of the bronchiolspasm. Again figure 3 illustrates graphically the rapid expiratory stroke of the respiratory apparatus when bronchiolspasm has been relieved. At the present time the patient remains free of bronchiolspasm as determined by the foregoing studies and symptomatically by the absence of wheezing.

Figure 4 will outline in summary form our methods of vigorous active therapy for progressive obstructive pulmonary atrophy (emphysema). Only by strong patient-physician relationship and attention to detail can such a regime be successfully carried to completion.

Summary

The term *pulmonary emphysema* no longer serves a suitable purpose and therefore should give way to a more descriptive one, such as *Progressive Obstructive Pulmonary Atrophy*.

The treatment of progressive pulmonary atrophy is basically a program designed about pulmonary patho-physiology. It requires control of infection by proper use of antibiotics and elimination of secretions.

Once bronchiolar spasm can be overcome and the infection eliminated, progressive pulmonary atrophy can be controlled. In a select group of cases permanent bronchiole dilatation can be maintained by proper denervation of the pulmonary root. Results substantiate our contentions as to the effectiveness of the surgical approach. Such surgery is merely an adjunct procedure and cannot succeed by itself. Proper preparation and selection of cases is paramount to successful surgery. In our opinion this disease demands greater effort at prophylaxis and a more vigorous therapeutic approach.

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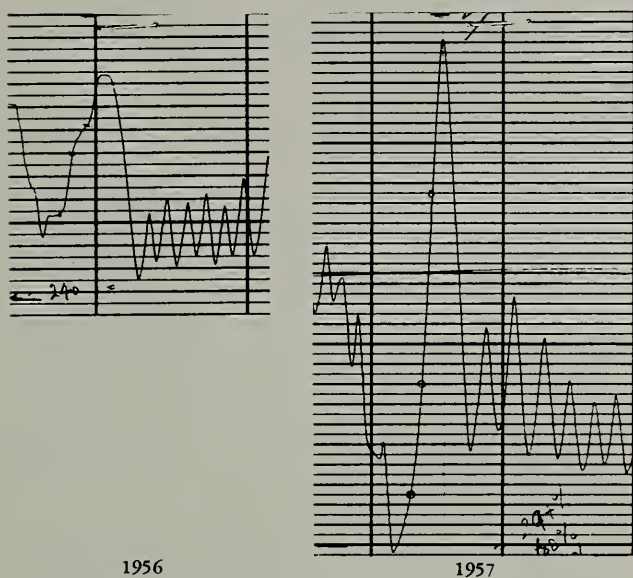


FIG. 3. (Paper moving from right to left.) Respiratory tracings made during the 1956 series compared to those made one year after surgery had been completed. Note improvement in the vital capacity and tidal volume. Respiratory rate markedly decreased. Likewise note very rapid downstroke of the postoperative curve indicating the absence of bronchiolspasm.

TREATMENT OF PULMONARY EMPHYSEMA

A. Prophylaxis

B. Active, energetic Therapy

1. Chest exercises

2. Antibiotics { Systemic Aeresol

3. Expectorants

4. Antihistamine

5. Bronchoscopy when warranted

C. Pulmonary Function studies and Pulmonary Artery studies

D. Vagotomy in selected cases

1. Bilateral and complete

FIGURE 4

Diuril® in Hypertension

JOHN MESSINA, M. D.

IN THE PAST 10 years there has been a most relentless clinical and investigative assault on the ravages of hypertension that has been productive of therapeutic regimes with encouraging effectiveness. Malignant hypertension has been reversed or forestalled repeatedly.¹ Regression of vascular disease, decrease in heart size, changes in the electrocardiograph, and objective clinical improvement have reflected the increasing rate of rehabilitation of the affected individual. Studies of mechanisms of action of the effective hypotensive drugs have led to a more complete understanding of hypertension itself.

Most recently there has been added to our impressive armamentarium, chlorothiazide.* In less

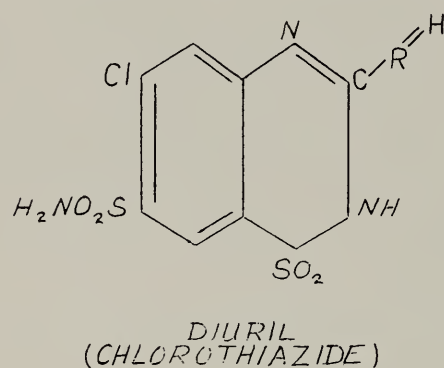


FIG. 1. Structural formula of chlorothiazide (6-chloro-7-sulfamyl-1,2,4-benzothiadiazine-1,1-dioxide [R=H]).

than a year, it has already established itself without much question as the oral diuretic of choice in edematous states. This, coupled with its marked hypotensive effect, promises to establish it as one of the more important advances in clinical medicine in recent years.

Clinical Study

This report is intended to present a clinical study on the use of Diuril on 29 patients with essential hypertension. Ages ranged from 40 to 72 years. Of these, there were 11 males and 18 females. The duration of therapy with Diuril alone or in combination with another hypotensive agent ranges from 2 to 4½ months. Of the 29 patients, 11 were treated with Diuril alone, and 18 were treated

The Author

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with Diuril plus another hypotensive agent. All of these patients were treated during regular office hours. All were ambulatory. No attempt was made to restrict salt intake beyond that used in the normal preparation of food. No intense weight reduction program was in effect for any of the patients. The average dose of Diuril used was 0.5 gram three times daily. In three instances this was increased to 1 gram three times a day.

Clinical Results

As noted in table 1, the average drop of blood pressure in 11 patients treated with Diuril alone was 48 mms. of mercury systolic and 28 mms. of mercury diastolic, with a range of 20 to 70 mms. of mercury systolic and 10 to 90 mms. of mercury diastolic. In table 2, it is noted that the average drop of blood pressure in 18 patients treated by a combination of Diuril and another hypotensive agent, usually Ansolysen,[®] Rauwolfia serpentina or Inversine,[®] was 45 mms. of mercury systolic and 26 mms. of mercury diastolic, with a range of 0 to 130 mms. of mercury systolic and 0 to 100 mms. of mercury diastolic. In only two patients was there no drop in systolic pressure, and in four patients there was no drop in diastolic pressure.

The maximum blood pressure response was noted within three weeks in a great majority of instances, oftentimes within the first week. Postural hypotension did not occur except in some of those patients treated concurrently with ganglion blocking agents. In most patients, the fall in blood pressure was a progressive one. In a few, the blood pressure response was erratic but with an overall pattern of decrease. It was common for the patients to lose 3 to 5 pounds during the first week of therapy, presumably due to the diuretic effect of the drug. This weight loss was not progressive in spite of continued administration of the drug. None of these patients studied were in con-

From a clinical study carried on at The Euclid Clinic Foundation, Cleveland, Ohio.

Accepted for publication before January 1, 1959.

*Trade name "Diuril." Supplied by Merck Sharp & Dohme for this investigation.

TABLES 1 AND 2.—*Decrease in Blood Pressure in Millimeters of Mercury*

TABLE 1.—DIURIL ALONE		TABLE 2.—DIURIL AND OTHER HYPOTENSIVES	
Systolic	Diastolic	Systolic	Diastolic
20	10	70	50
50	22	50	20
50	22	20	50
50	20	130	40
80	20	40	20
35	15	80	20
55	40	70	100
70	90	45	10
30	20	30	15
40	40	0	0
50	10	60	25
Average	48	60	30
		35	25
		60	70
		10	0
		40	20
		0	0
		20	0
		Average	43
			27

gestive failure and the effects of the diuretic action of Diuril were less marked.

Laboratory Results

After two months of continuous therapy, serum sodium, potassium, and routine blood and urine examinations were done in 13 patients. In only one instance did the serum sodium fall below the normal levels; this was 133 mEq. of sodium. This patient was asymptomatic and demonstrated no unusual signs or symptoms. In no instance was the serum potassium below 3.1 mEq. The remainder of the tests were within normal limits. No abnormalities were demonstrated in the hemogram or the urine.

Side Effects

Here we noted, as others have repeatedly, the unusual lack of side effects in a drug as potent as Diuril. There was transient lassitude in three patients during the first two days of therapy. This cleared during continued administration of Diuril. Nausea of no consequence occurred in one patient. Three patients noted the appearance of disturbing palpitation. In one it was necessary to reduce the dose to 250 mg. three times a day for a few days; with the restoration of the original dose of 0.5 grams thrice daily there was no difficulty. The other two cleared with continued use of Diuril.

In three instances the dose of Diuril was increased to 1 gram three times a day. One of these patients demonstrated a further drop in blood pressure, making continued use of the drug desirable; after two months he has shown no adverse clinical effects. The other two patients had no further drop in blood pressure and it was decided to revert to the dose of 0.5 gram three times a day.

Discussion

Since the synthesis of chlorothiazide by Novello and Sprague² and their initial report of the saluretic (promoting loss of sodium and chloride

in equimolar quantities) effect of Diuril by Bayer, Russo and Haimbach,³ many studies have established it as the diuretic of choice. Although closely related to the sulfonamides, it has shown a constant lack of serious side effects clinically and in the laboratory. To date, I know of no serious reactions with recommended dosages. Because of the saluretic effect and because it doesn't cause marked excretion of potassium and bicarbonate except in high dosages, usually 4 grams and over per day, it has very little tendency to produce metabolic acidosis or alkalosis, as is more common with the mercurials and the carbonic anhydrase inhibitors.

The hypotensive action of Diuril has been documented in many recent reports.^{3, 4, 5, 6} Several investigators feel that the hypotensive action is directly related to the sodium depletion and diuresis that occurs. In support of this view, recent reports by Freis⁸ and others strongly point to reduction in plasma volume as the principal mode of action of Diuril in decreasing blood pressure. Repletion of the plasma volume with dextran elevates the blood pressure to pre-Diuril levels. Diuril has produced a drop in blood pressure, even without a significant decrease in serum sodium or weight. He also noted that Diuril is not hypotensive in the normal patient, but it reduces blood pressure greater and more rapidly than salt restriction alone.

Freis et al.⁸ and Wilkins⁹ were able to demonstrate, as others have, that Diuril reduces the need for other hypotensive agents to an average of 50 per cent of the previous dose. In many instances, it was mandatory to reduce the ganglion blockade type of drug because of marked postural hypotension. Diuril used alone, as noted previously, does not produce postural hypotension. Whether this implies sensitization of the autonomic nervous system by Diuril to these other agents

or not, is not definitely decided but strongly implied.

In view of our own experience with Diuril and the experiences recorded repeatedly by many investigators throughout the country, it is recommended that the order of treatment of hypertensives of nonspecific etiology should be first with Diuril, secondly with the addition of Rauwolfia serpentina, thirdly with the addition of ganglion blocking agents in the less responsive patients.

Summary

A clinical experience with an interesting hypotensive agent, Diuril, is presented. Its marked hypotensive effect is clearly demonstrated in a great majority of 29 patients treated with Diuril alone and in conjunction with other hypotensive agents. Its mechanism of action appears to be strongly related to its saluretic effect and in the concomitant decrease in plasma volume resulting from the diuresis. Coupled with its marked hypotensive qualities is its intense diuretic effect in edematous states. To complete a most imposing triumvirate is the impressive lack of clinical or laboratory side effects in the recommended dosage of 2 grams or less per day.

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Methocarbamol in Orthopedics

A new skeletal muscle relaxant, methocarbamol, was used in the treatment of 38 patients with a variety of severe neurological disorders and skeletal muscle spasm states. Eighty-two per cent of the patients studied obtained a beneficial result ranging from excellent to fair. Mild side effects such as drowsiness were observed in five patients, mild weakness in three, and excessive perspiration in one. In two of the five patients who complained of drowsiness, it disappeared upon reduction of dosage and did not reappear when original dosage was reinstituted.—William B. Lewis, M. D., Riverside, Calif.: *California Med.*, 90:26, January, 1959.

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEPFEL, M. D.
Columbus, Ohio, Chairman

Following is the summary of a case which was discussed before the Franklin County Pelvic Cancer Delay Committee on December 17, 1958, at its regular monthly meeting held at the University Health Center.

Case No. 66. Patient is a 69 year old white woman who first saw her physician in August with a history of vaginal bleeding for a period of one year. Cervical biopsy reveals squamous cell carcinoma of the cervix, clinical stage three. The patient had external x-ray therapy given the following month, the total of 20 treatments. Tumor dose was approximately 3000 r.

This patient received no central therapy with recurrence of bleeding two months later. Patient was referred for completion of therapy.

Pelvic examination reveals frank tumor involving anterior and posterior vaginal walls and extension to both pelvic walls. There is encroachment by tumor mass on the rectosigmoid junction.

Comments

DR. EZELL: There is but one opportunity to treat carcinoma of the cervix adequately. Upon initial diagnosis the continuous and complete therapy necessary to eradicate the disease must be applied.

DR. POMEROY: We agree that therapy should be given in a combined form for cervical carcinoma. This combined form entails external x-ray directed to the mid-pelvis and central therapy given in the form of radioactive cobalt. The application in a uniform manner which avoids loss of time between central therapy and external therapy is an absolute necessity. The factors of time and dose are the prime considerations in good therapy. This patient had neither. At this point we are able only to use palliation on this individual.

DR. HOLZAEPFEL: Time loss on part of patient was one year. Time loss between first medical consult and adequate therapy was 17 months. This amount of time loss must be shared by patient and physician. Although this patient did not tell her physician, she was bleeding for a period of one year and had been seeing this physician throughout that time. A pelvic examination must be done in a 69 year old woman at least every six months regardless of presenting symptoms.

DR. BOUTSELIS: Radiation therapy and investigation of carcinoma should be carried out in a Center wherein there is proper equipment to deliver that therapy.

Current Concepts for Treatment of Fractures of Long Bones Due To Multicentric Cancer

RICHARD F. SLAGER, M.D.

THE therapy in pathological fractures of long bones due to a benign process is universally directed toward restoration of function and normal motion. Amputation is the choice of therapy for the majority of primary bone tumors limited to an extremity. Little unanimity exists however as to the treatment of fractures of long bones due to a generalized malignancy. Very few statistics have been collected which give one a basic approach to the problem and it was hoped that a review of the five year statistics at Ohio State University Hospital would clear some of the indecisiveness. The patients were evaluated as to the mode of therapy and the eventual result.

All recent reviews demonstrate that osteomyelitis¹ has clearly given way to antibiotics and that metastatic cancer has become the most frequent cause of pathological fractures of long bones. The overall incidence is appreciated when we review Copeland's study.² He found, that 15 per cent of those patients with cancer had metastases to bone. Of the patients with bone metastasis, approximately 15 per cent will have a pathological fracture.

The grave prognosis of these patients is understood when we observe the results of the series of Welch, even though it does not include antibiotics and the more recent palliative measures of oophorectomy, adrenalectomy and/or hormonal therapy it demonstrated the trend. Twenty-five per cent of the patients died within the first month post-fracture due to a malignancy, and an additional 25 per cent were dead within two months. The total mortality was 75 per cent at the end of one year. There is, unfortunately no absolute way of predicting the course or life expectancy in this group with multicentric cancer. The per cent, therefore, that should receive definitive therapy for their fracture is actually greater than 50 per cent if definitive therapy will decrease the morbidity.

There were 38 patients with pathological fractures of long bone in this series, 31 being due to metastatic cancer. The sex ratio was 4 to 1 in favor of the female, being somewhat explained by the fact that 42 per cent of the multicentric tumors primarily came from mammary tissue. The humerus or the femur was the site of the fracture in

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83 per cent of the fractures. Fifteen of the 31 fractures were transfixed by intramedullary fixation. Ten had fractures that could have been repaired surgically but were treated by the non-surgical methods of plaster, slings, and/or x-ray. The remaining six were not candidates for surgery due to their terminal condition or type of fracture.

Healing of the fracture and prevention of deformity, two of the principal objectives in general fracture management are relegated to positions of lesser importance in pathological fractures due to malignancy. Here the approach of treatment is directed toward adequately fulfilling five objectives: (1) Freedom from pain; (2) Restoration of ambulation; (3) Activity independence; (4) Patient's morale; (5) Return of maximum function with minimum risk to the patient.

Freedom from Pain

The criteria for evaluating pain relief was classed as (a) a poor result when the patient demanded more narcotic post-therapy than pre-therapy, (b) a fair result when the narcotics demanded were the same as pre-therapy, (c) an acceptable result when the pain was controlled by aspirin and small doses of codeine, and (d) a good result when the pain was relieved and the patient demanded no medication. Twelve of the 15 patients treated by intramedullary fixation had good or acceptable pain relief: only one of the 16 patients treated conservatively by plaster, radiation, sling, or any combination of these had a good or an acceptable result.

However, not all fractures can be treated by intramedullary fixation as in the case demonstrated by figure 1. The patient has cancer involving the proximal femur, precluding stability if intramedullary fixation was attempted. The patient was immobilized by bilateral short leg casts with a cross bar (Fig. 2). (Roger-Anderson well-leg traction would undoubtedly give the same relief and pro-

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vide more immobilization). This was the one patient treated conservatively that had acceptable relief of pain.

Restoration of Ambulation

Intramedullary fixation was the method of choice in fractures of the lower extremity since only those patients that had intramedullary fixation were able to tolerate weight bearing upon the fractured lower extremity. One-half of those fractures of the femur treated by intramedullary nailing became ambulatory. Two of the six that were ambulatory could walk without the support of a walker, crutch or a cane.

Activity Independence and Morale

It is obvious that uncontrolled pain and a bulky cast would increase the demands for nursing



FIG. 1. A fracture that is not conducive to intramedullary fixation.

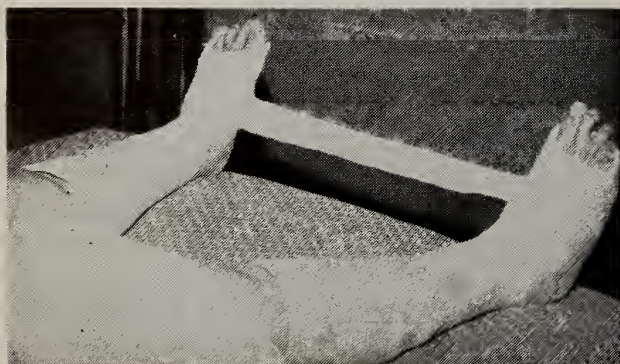


FIG. 2. One method to partially immobilize a lower extremity.



FIG. 3. A femoral shaft fracture in a bedridden patient immobilized by an intramedullary rod.

care as would the inability to walk. For this reason, whenever possible intramedullary fixation should be used since it not only aids ambulation, decreases pain, but it makes a more manageable patient who is more independent in his activities.

The despair and uncooperativeness of the patient who has just received a pathological fracture is quite marked. Often the patient will speak only of his impending death. If he is bound in a large cast the discomfort is just as depressing. Radiation and slings only tend to increase their feeling of uselessness, since the extremity has no function. No other single point was as gratifying as was the marked increase in the patients' feeling of well-being and the families' gratitude for the boost in the patients' morale.

Maximum Function at a Minimum Risk

Two of the 15 patients in the Ohio State University series died prior to their leaving the hospital, aided by a complication of the surgery. This demonstrates the inability of these patients to withstand the surgery and the importance of short and minimally traumatic procedures.

One minimally traumatic method of immobilization of a shaft fracture of the femur in a bedridden patient can be accomplished by reflecting the patella medially upon a flexed knee; this gives a full exposure of the intercondylar notch and a rod can be

passed up the shaft of the femur. A small finger hole to the fracture site will realign the fragments and direct the pin adequately. Figures 3 and 4 demonstrate the fracture pre- and postoperatively as well as show the small wounds necessary for this exposure. The surgery in this case was with a local anesthetic of 1 per cent Xylocaine®. Since the pin is free to extrude into the joint, this method of reduction should be reserved for those not ambulatory prior to the fracture.

The factors of depression, shock and morbidity were to these patients of such magnitude after a fracture that it would be ideal if some method could be used to predict those bony lesions that would result in a fracture, so that prophylactic surgery could be attempted.

Twenty-five of 31 patients with pathologic fractures due to multiple focus cancer had been known to have cancer prior to the fracture. Long bone surveys would make evident progression and the location of the bony lesions. Intramedullary fixation in an involved bone which is intact is a relatively easy procedure, however, when the bone ends are displaced after the fracture, the reduction

can be quite difficult. The procedure also entails more manipulation in the area of the tumor.

A review of the roentgenograms of the patients with the fractures demonstrated that fractures occurred in two different types of involved bone. There were those with a generalized involvement and those with a solitary lesion. It was the latter group that we feel should be examined further for consideration of prophylactic surgery. It was noted that in all of these fractures at least 50 per cent of the cortex was involved prior to the fracture.

It was interesting that 67 per cent (20 of 30) of these patients with pathological fractures occurred in those who were moderately overweight or obese (Figure 5) (the weight of the thirty-first patient was not taken due to her terminal state). This is of increased significance when it is realized that a relatively small percentage of patients with metastatic disease are obese or overweight.

Conclusions

Despite the poor prognosis of the patient with a pathological fracture of a long bone due to multifocus cancer it is of value to give him palliative therapy. Intramedullary fixation is shown to be the method of choice for immobilization. However, every effort should be made to make the procedure as simple as possible because of the inability of these patients to withstand major operative procedures.

Obese patients and moderately obese patients with solitary metastatic cancer lesions in long bones should be evaluated by frequent bone surveys. The incidence of pathological fractures in this type of patient was well above the expected percentile in this series and it is therefore this group which should have prophylactic intramedullary fixation if 50 per cent of the cortex is involved in the lesion.

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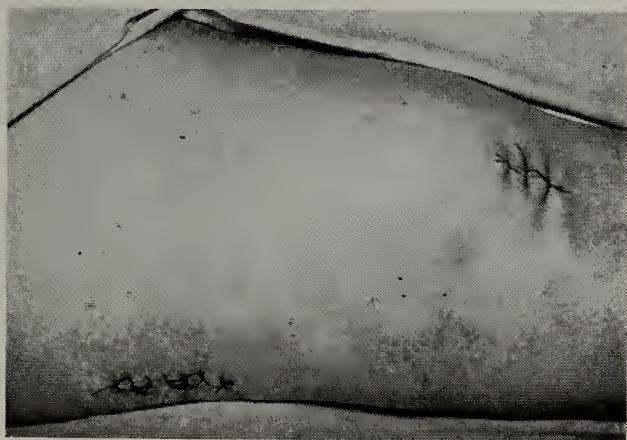


FIG. 4. Operative areas for intramedullary rod insertion in figure 3.

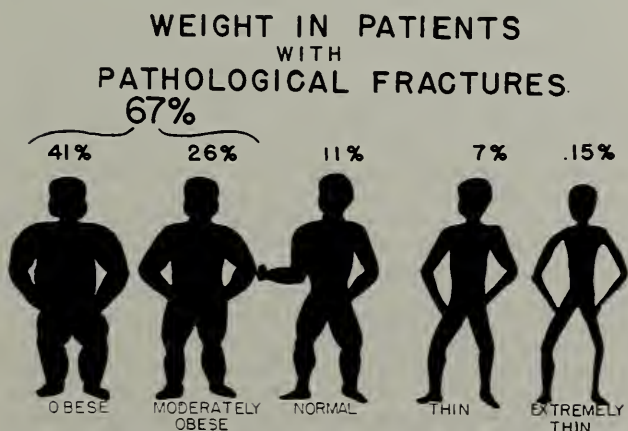


FIG. 5. Weight distribution of patients with long bone pathological fractures due to cancer.

Abdominal Actinomycosis — A Case Report*

JOHN R. CUMMINGS, M. D., MARTS E. BEEKLEY, M. D. and
NEAL EARLEY, M. D.

FROM the year of its discovery in man in 1845^{1,2} until 1936, actinomycosis was treated principally by means of surgery, potassium iodide and irradiation. During the past 13 years bacteriostatic agents, the sulfonamides and the antibiotics have been effectively utilized in the treatment of actinomycosis.^{3,4,5} In more recent years the disease has also been treated by means of anti-tuberculous agents.⁶

The difficulty encountered in arriving at the correct diagnosis for a chronic granulomatous disease associated with or without a draining sinus, is exemplified by the case here recorded, and stems not so much from the fact that the possibility of actinomycosis was not considered in the early phase of the patient's illness, but more from the lack of proper procedure from a bacteriologic standpoint.

The clinical manifestations of the disease, adequately recorded in other publications, will be repeated here only in the case report. In the final analysis the diagnosis of actinomycosis depends chiefly upon laboratory examination. These include: (a) The gross and microscopic examination of the *Actinomyces*, "sulfur" granule, (b) The Gram stain to demonstrate the *Actinomyces* as gram-positive branching filaments associated with diphtheroid and coccoid forms, and (c) The cultural characteristics showing the *Actinomyces bovis* to be a partially anaerobic microaerophilic organism.^{7,8}

Case Report

The patient, a 39 year old white draftsman, was admitted to The Christ Hospital, Cincinnati, on September 9, 1957, with a history dating back to February, 1956. At the onset of his illness in February, 1956, he was having generalized abdominal pain, fever, anorexia and fatigue, but no vomiting or diarrhea. The pain moved to the right side of the abdomen and then to the right shoulder. The pain was not related to meals, and there was no change in the color of the urine or stool. The abdomen remained sore while the patient was under the care of his family physician, who treated him with penicillin. By May, three months after the onset, he had lost 20 pounds in weight. Treatment, using penicillin and antibiotics, continued through June and July. In late August he began to have chills.

He was admitted to the hospital on August 18, 1956, and was found to have a tender liver, palpable two finger breadths below the right costal margin. There was also some tenderness in the right side, especially in the right upper quadrant and in the right flank. His red blood cell count was 3,760,000 with a white blood cell count of 16,000 showing 71 per cent polymorphonuclear leuko-

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cytes. The urine analysis was negative and reaction to the Kahn test was negative.

On August 28, 1956, a liver biopsy was done and 14 hours later the patient had increased right abdominal tenderness, abdominal rigidity and a hepatic friction rub. The total serum protein, thymol-turbidity and blood urea nitrogen were normal. Stool examination for schistosomiasis was negative. X-ray studies of the chest, flat films of the abdomen, oral cholecystogram and upper gastrointestinal x-ray studies were all done between August 18 and August 22, and were reported as normal. Fluoroscopic examination of the chest on September 1, 1956, showed the right diaphragm to be elevated and fixed, and there was evidence of a minimal amount of fluid in the right costophrenic angle.

On September 5, an intravenous pyelogram showed a normal left kidney and ureter, but the right kidney and ureter were unsatisfactorily visualized. Films of the alveolar regions showed no root abscesses. The patient had fever of 100 to 101 degrees Fahrenheit while hospitalized. The report of insufficient tissue for diagnosis was the result of the liver biopsy, although some neutrophils and foam cells were described. It was suggested that the specimen may have been taken from the edge of an abscess. The patient was treated with penicillin and streptomycin for six days and dismissed from the hospital.

The patient's second admission was from October 3 to October 25, 1956. On that admission it was noted that he had lost 35 pounds in weight, and there was described the presence of a mass approximately the size of a baseball, located in the very tender right upper quadrant of the abdomen. A fluctuant mass measuring approximately 6 by 8 cm. was present in the right flank. Urine analysis showed 4 plus glucosuria; the fasting blood sugars were 306 mg. per 100 ml. and 220 mg. per 100 ml. Stool specimens were negative for schistosomiasis. An intravenous pyelogram on October 4th showed considerable spindling of the calyces in the right kidney.

On October 11th, an incision and drainage of the fluctuant mass was accomplished. Large granules were recovered and actinomycosis was suspected. Culture produced no growth. The patient was maintained on 30 units of NPH insulin each day and dismissed with a diagnosis of perinephric abscess and diabetes.

His third admission was from November 12 to November 20 in 1956. At that time he was complaining of left chest pain and associated left shoulder and arm pain. Chest x-ray examination showed the right diaphragm to be elevated with some evidence of pleural thickening and fluid at the right base. Lipiodol® was injected into the

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sinus tract in the right flank and reached the level of the lower pole of the right kidney and was described as appearing not in the retroperitoneal space but in the muscular area. No connection with the kidney was visualized in the lateral view. An electrocardiogram showed marked left axis deviation. Sputum cultures were negative. An upper gastrointestinal series done on November 19th showed evidence of extrinsic pressure on the apex of the duodenal bulb. The patient was dismissed with a diagnosis of abdominal abscess, probably pancreatic in origin.

He was admitted to another hospital on December 6th and after completion of studies in regard to his diabetes, and after consideration of the possibilities of hyperlipemia, agammaglobulinemia and parathyroid disease, he was dismissed on December 20, 1956, with a diagnosis of possible diabetes secondary to chronic pancreatitis and anxiety neurosis.

He was seen in the Christ Hospital outpatient clinic on August 14, 1957. At that time a draining sinus tract was present in the right flank, and in the region of the posterior portion of the crest of the right ilium a fluctuant mass was present. This mass was incised and drained. At the time of incision, whitish-yellow flakes of material were recovered. The suspicion of actinomycosis was again aroused and verified by observation of the ray fungus under the microscope. Characteristic mycelia were observed in sodium hydroxide suspension and the *Actinomyces bovis* was cultured as an anaerobe. The patient was admitted to this hospital on September 9th, 1957.

Physical examination showed a well developed, slender white man with a draining sinus tract in the midportion of a 3 inch right flank incision, the center of which contained a granulomatous mass measuring approximately 2 by 2 cm. in diameter. The external orifice of another sinus tract was present in the skin at the approximate level of the right posterior iliac spine. This orifice measured 4 mm. in diameter. Only serous exudate could be expressed. The tract could be explored for approximately five inches. Temperature, pulse and respirations as well as the blood pressure were normal. There was some dullness to percussion at the right lung base posteriorly, and the remainder of the physical examination was normal.

Laboratory Findings: Using a Gram stain and microscopic examination, gram-positive filamentous rods, clubs with true branching and fragmentation were noted. Using a thioglycollate fluid medium, a typical small colony growth was obtained in four days. Subcultures on brain heart infusion agar plates using 100 per cent carbon dioxide, resulted in a good growth in five days. In brain agar plates, utilizing brain heart infusion agar with paraminobenzoic acid and 5 per cent concentration of sheep's blood, poor growth was obtained aerobically. Subculture in a Bray dish under anaerobic conditions resulted in good growth. Morphologically the organisms proved to be gram-positive branching, filamented and clubbed forms consistent with Bergey's description of *Actinomyces bovis*.^{*} The organism was sensitive in vitro to penicillin, Achromycin,[®] streptomycin, chloramphenicol, Terramycin,[®] sulfadiazine and sulfathiazole.

Hemoglobin was 13.8 grams with the red blood cell count 4.4 million. The white blood cell count was 5,000 with 68 per cent polymorphonuclear leukocytes, 29 per cent lymphocytes and 3 per cent monocytes. Urinalysis showed a specific gravity of 1.023 with a rare WBC and a rare RBC. The cephalin-cholesterol flocculation test was negative in 24 and 48 hours. The fasting blood sugar was 158 mg. per 100 ml. and the glucose tolerance curve was diabetic in type. Serum protein was 6.4 Gm. with 4.11 grams of albumin and 2.3 Gm. of globulin. The blood urea nitrogen was 11 mg. per 100 ml.

Course in Hospital: On September 12th the sinus tract was injected with 35 per cent Diodrast[®], x-rays were taken after the injection and showed the sinus tract extending deeply to a pooled area lateral to the cecum.

The patient was maintained on a diabetic regimen including a 2200 calorie diet and 20 units of NPH insulin

each day. He was started on 3 grams of sulfadiazine daily, divided into six equal doses and he received 500,000 units of aqueous penicillin intramuscularly every six hours. This was continued for two months, the period of hospitalization.

During the next two months penicillin was given as procaine penicillin in the amount of 500,000 units every 12 hours and during the succeeding two months as procaine penicillin in the amount of 500,000 units once a day. Sulfadiazine is to be continued for six months in a dosage to maintain the blood serum level at 8 to 11 milligrams per 100 ml.

While hospitalized, repeated blood counts showed no evidence of agranulocytosis and urinalyses no evidence of crystalluria. After three weeks of treatment the sinus tract closed. Should agranulocytosis or crystalluria occur tetracycline is to be substituted for the sulfadiazine.

Summary and Conclusions

A case of actinomycosis is reported and emphasizes the fact that consideration of actinomycosis as a possible cause for chronic granulomatous sinus tracts coupled with properly performed bacteriologic studies will result in the establishment of a definite diagnosis. With the diagnosis confirmed, adequate protracted therapy can be instituted to effect an arrest or cure of the infectious process.

It is quite possible that the focus of infectivity was, in this case, present in the appendix. An appendectomy, in the future, is included in the plan of treatment.

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Effectiveness of Long-Term Treatment Of Malignant Hypertension

Although hypertension, even of mild degree, shortens the life span, survival is improved in those patients who undertake treatment with anti-hypertensive drugs before malignant hypertension has caused extensive vascular damage. Patients who begin receiving treatment after evidences of severe renal damage are apparent usually do not survive for long periods. However, several such patients have maintained active lives for many months and years. Therefore, treatment should be withheld in only the most desperate circumstances.—Abstracted from: Harriet P. Dustan, M.D.; Roland E. Schneckloth, M.D.; A. C. Corcoran, M.D., and Irvine H. Page, M.D., Cleveland: *Circulation*, 18-644-651, October, 1958.

^{*}Cultures by E. A. Schmidt, M. S., Department of Bacteriology.

Leiomyosarcoma of the Ileum with Perforation

A Case Report and Brief Review of the Literature

JAMES J. MAURER, M.D.

THE diagnosis of an acute abdomen, at times, presents a great challenge. This paper presents one of the less common pathologic lesions causing an acute abdomen. A perforated small bowel at the site of a neoplastic lesion is quite rare.¹ Still more uncommon is the combination of a diverticulum, neoplasm and perforation.

Case Report

The patient, a 65 year old male, was previously admitted to the hospital on June 10, 1952, complaining of abdominal pain and diarrhea for two weeks. Prior to admission he had severe anemia. X-ray studies revealed

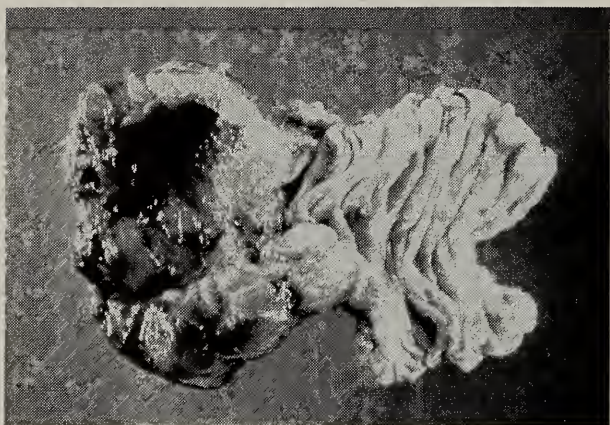


FIG. 1. Resected segment of ileum and tumor.

two diverticula seen in the sigmoid colon and also an irritable duodenal cap. Red blood cell count of 2.86 million and hemoglobin of 8.5 Gm. Having been treated with a conservative regime, he was discharged as a patient with an acute duodenal ulcer with hemorrhage.

On February 19, 1958, the patient was brought to the hospital because of the onset of severe abdominal pain five hours prior to admission. The pain became progressively worse and his abdomen became distended. Other than the previous admission the past history was not remarkable.

The physical examination revealed a blood pressure of 190/70, temperature 98.4°, respirations 18 and pulse 96. The pertinent findings were limited to the abdomen, which was markedly tender to palpation in all quadrants and rigid. The abdomen was distended, bowel sound and liver dulness were absent. A flat film of abdomen revealed free air under the diaphragm. On admission the red blood cell count was 5.61 million, hemoglobin 15.6 Gm. and the white blood cell count was 6,500 with 81 per cent neutrophils.

The patient was taken to the operating room and the abdomen was explored through an upper right rectus incision. A milky, pus-like fluid was present in the abdominal cavity but no lesion was demonstrated in the upper abdomen. Further exploration of the lower abdomen was carried out and what appeared to be a perforated, gangrenous diverticulum was found. This mass

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was arising from the antimesenteric border of the proximal ileum. This portion of bowel was resected and an end to end anastomosis performed.

Another diverticulum was observed at the mid-jejunum but due to the patient's poor condition no further surgery was undertaken and the abdomen was closed. He was placed on antibiotics, had a good postoperative course, and was discharged March 8, 1958.

Discussion

The resected mass measured 6 cm. and presented a rough, dark-red surface. There was a perforation at the apex which led to a central cavity with a ragged red lining. A small constricted stoma then led into the lumen of the otherwise normal intestine. The wall of the mass measured up to 1.5 cm. in thickness and was soft, slightly granular and pale gray-pink. These findings are demonstrated in figure 1.

The tumor infiltrated the muscularis and grew toward the lumen to produce mucosal ulceration and also grew extrinsic to the muscle to produce a large mass. This was made up of irregular bundles of cells which generally had a spindle shape, but which were oval or even round. The elongated nuclei were of varying size and showed

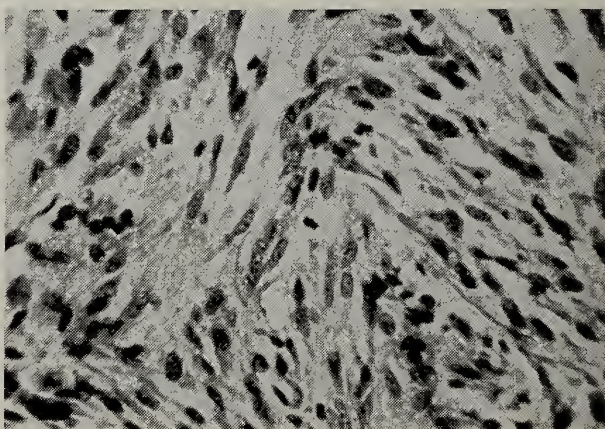


FIG. 2. A photomicrograph of resected tumor.

considerable variation in chromatin distribution. In spite of this cellular anaplasia, mitosis was quite rare. A photomicrograph, figure 2, illustrates the cellular pattern with rounded nuclei and a mitotic figure.

A diagnosis of leiomyosarcoma was made.

Comment

According to Cullen,² the most common symptoms of this entity are vague abdominal pain, tarry stools and anemia. The findings on the first ad-

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mission may very well have been caused by this leiomyosarcoma. Ripstien³ states that the bleeding may be either into the gastrointestinal tract or into the peritoneal cavity, the tumor being manifested either as recurrent intestinal bleeding or an acute abdomen. It was our feeling that the diverticulum was secondary to the neoplasm. Brunk⁴ proposed the theory that a "Meckel-like diverticulum" could be formed at the site of a tumor in the ileum, the new growth forming a weakness in the bowel. Malignant tumors have been described in a Meckel's diverticulum^{5,6} which this case was first thought to represent.

However, no matter what the cause of the diverticulum, the end results are essentially the same when perforation occurs.

Summary

A case of a perforated leiomyosarcoma of the ileum is presented. The literature has been briefly reviewed with respect to tumors of the small bowel and their perforation.

Acknowledgment: I wish to express my gratitude to Dr. Daniel E. Earley for allowing me to report this case.

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The Hemophilia Problem

Hemophilia no longer is considered to be a single disease entity. Deficiencies of the presently recognized precursors of plasma thromboplastin, namely antihemophilic globulin, plasma thromboplastin component and plasma thromboplastin antecedent, give rise to a variety of diseases. Recognition of the type of defect of coagulation that is present is important because treatment and prognosis vary according to the nature of the defect. Laboratory studies are of great importance in differentiating the various hemorrhagic states formerly considered as the disease "hemophilia." The chief treatment of classic hemophilia and of the more recently recognized variants of this condition remains the administration of whole blood or plasma.—William F. Westlin, M. D., Stephen D. Mills, M. D., and Charles A. Owen, Jr., M. D., Rochester: *Minnesota Med.*, 41:705, October, 1958.

Anencephaly in One Twin (A Case Report)

By M. M. Thompson, Jr., M. D.*

Ru-Kan Lin and Henry P. Plenk state that anencephaly occurs not uncommonly in single pregnancies, but that it is quite rare in twins. They report the incidence in single pregnancies as averaging 0.72 per 1,000 births in an accumulation of 434,667 births. Of the 315 cases of anencephaly in the accumulated series twins were involved nine times, only one twin seven times and both twins the other two times. They report a case of anencephaly in both twins diagnosed antepartum.

A case of anencephaly in one twin diagnosed antepartum is reported herewith.

Case Report

Mrs.—, a 29 year old white housewife was x-rayed on October 7, 1953, for the possibility of twins or polyhydramnios. She had borne three children, one of which was born dead. The last menstrual period had been on February 21, 1953. Quickening was felt on July 6th. The estimated date of confinement was November 29, 1953.

The patient's past history revealed that she had the usual childhood diseases, scarlet fever and arthritis. The present pregnancy was uneventful except for monilia vaginitis in May. She had gained 35 pounds in weight.

Physical examination at the time of delivery revealed that the uterus extended to the ensiform cartilage, but was otherwise within normal limits.

The x-ray examination revealed twin fetuses in utero with the heads presenting. The presenting fetus appeared normal. The second fetus was anencephalic. Polyhydramnios was present.

Normal labor occurred on November 1, 1953, with two female infants delivered. The first infant weighed 4 pounds 15 ounces and was normal. The second weighed 3 pounds 10 ounces and was anencephalic and died approximately one hour after birth. No other abnormalities were recognized in the anencephalic infant on physical examination. The postpartum course was uneventful.

Summary

A case of anencephaly occurring in a twin pregnancy, diagnosed antepartum by x-ray is reported.

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*Dr. Thompson, Toledo, is Director of Radiology at Mercy and St. Luke's Hospitals.

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MATERNAL HEALTH IN OHIO

Case No. 124

This patient was a 32 year old, Negro, unknown gravida and Para who died undelivered. No information was obtained concerning her past obstetrical, medical or surgical history.

About noon, January 27, the patient suffered abdominal pain, and vomited. Details of recent menstrual periods not available. According to fragments of information, she prepared to go to the hospital, then improved and decided not to go. Approximately 7:40 a.m. January 28, she became acutely ill, was taken to the hospital by police ambulance, arriving there unconscious at 8:05 a.m.

Examination revealed she was in shock, BP 50/? , abdomen soft, chest and lungs clear, "Rectal and vaginal—NSA" (no specific abnormality). She was given ephedrine intramuscularly; intravenous fluids and blood expanders were given via "cut down." Oxygen was administered. She expired at 9 a.m., January 28.

Pathological diagnosis: (Coroner's autopsy). Ectopic pregnancy, right tube with spontaneous rupture and intra-abdominal hemorrhage.

Comment

The Committee reviewed this case with a great deal of interest, particularly with a question of accuracy of findings reported from vaginal examination. From facts reported, it was obvious the patient waited too long for medical advice and aid.

The case was voted a preventable maternal death, patient responsibility (P₁).

Case No. 196

This 26 year old white gravida II, Para O, abortus I, died four and one-half hours after delivery. She had miscarried a six-weeks pregnancy in November and according to her history bled profusely for two weeks thereafter. She registered in February. No menstrual period intervened between this episode and the onset of the pregnancy which terminated in her death. Precise staging of gestation was therefore uncertain. Her physician estimated a 2½ to 3 month pregnancy. She was estimated to be at about 38 weeks when terminal events occurred.

Her prenatal course was characterized by episodes of bleeding which resulted in recurring anemia treated by hematinics, hospitalization, and three blood transfusions. Occasional spells of weakness and vague sensations of pressure were her only other complaints. She was confined to her bed from time to time to control bleeding. Just prior to admission on August 4th she noted increased weakness, pelvic pain, and cramps.

On admission scant vaginal bleeding was described; blood pressure 92/60, hemoglobin 58 per cent, red blood cell count 3,100,000. X-ray showed head in "upper left iliac fossa." A diagnosis of 38 weeks pregnancy with partial abruptio was made and the patient given 1000 cc. blood and taken to surgery. Blood pressure then 120/60. Under spinal anesthesia the abdomen was opened and an

TOPIC THIS MONTH:

Maternal Deaths* Involving Ectopic Pregnancy

abdominal pregnancy was encountered. A 6 pound 6 ounce female infant was delivered and cried without resuscitation. Blood was found in the amniotic sac. The placenta was in the pelvis with considerable blood and clots. Because it was already more than 50 per cent detached it was removed, whereupon the patient although receiving blood went into deep shock from which she failed to recover in spite of 2000 cc. of blood and all supportive efforts. No autopsy was performed.

Cause of Death: Hemorrhage from partial detachment of placenta (right pelvis); extrauterine pregnancy, 9 months.

Comment

With only one dissenting vote the Committee considered this a nonpreventable maternal death. The infrequency of abdominal pregnancy alone commands interest and study. Invariably the question of the management of the placenta comes up for discussion. Because it was found to be already more than 50 per cent detached there would appear to be no option in this case. Hemorrhage in the face of pre-existing anemia is likely to be accompanied by serious troubles. Advantages to earlier diagnosis in this case would be doubtful. Every abdominal pregnancy possesses calamitous features and taxes the skills and judgment of the most experienced obstetrician.

Case No. 250

This 36 year old Negro gravida VII, Para VI, died 40 minutes after being brought to the Emergency Room. No information was available concerning her past medical, surgical or obstetrical history. She noted sudden abdominal pain two hours prior to admission and visited her physician who in his office found her blood pressure and pulse unobtainable. He gave her Demerol® 50 mg.

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by official representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

intravenously and brought her to the hospital immediately where intravenous fluids and oxygen were given, immediately followed by 2000 cc. of blood under pressure via cut-down. Hemoglobin was 5.8 Gm. Patient expired while being prepared for surgery. Chest was opened, and heroic efforts at resuscitation were unsuccessful.

Pathological Diagnosis: (A coroner's autopsy revealed) ruptured right tubal pregnancy with hemoperitoneum.

Comment

The Committee voted this a nonpreventable maternal death. The speed with which the patient's condition deteriorated despite reasonably prompt and correct supportive measures seemed to preclude a successful outcome. This case can provide good material for the academic argument of correcting shock before surgical intervention versus immediate surgery in the presence of profound shock to stop intraabdominal blood loss earlier. Under the circumstances described, identical end results probably would have been obtained.

Comment of Consultant

The following comment of a consultant who is a specialist in obstetrics and gynecology, was given at the request of the Committee.

The value of these three cases should be self-evident. Early diagnosis and properly instituted therapy are essential in the treatment of ectopic pregnancy be it tubular or abdominal.

In many instances a catastrophic episode is the initial event in the history of tubular pregnancy. However, this is unusual, and the prudent historian and examiner who will urge early examination in suspected pregnancy would do well to investigate those with pelvic pain, vaginal spotting, and delayed or abnormal menses. A high degree of *suspicion* is a definite asset in the early diagnosis of ectopic pregnancy.

Aspiration of the cul de sac or posterior colpotomy are simple diagnostic procedures which should be included in the armamentarium of all. By such procedures, the diagnosis of a hemoperitoneum may be established and the necessary procedure to prevent further loss of blood can be carried out.

In **Case 124** and **Case 250**, nothing of educational value can be gathered from the record. Both cases were catastrophic at the onset with death ensuing in each case less than one hour after admission to the hospital. One might question the advisability of administering intravenous Demerol to someone in shock and what constitutes proper "preparation for surgery" in someone with obvious evidence of intra-abdominal hemorrhage. Those of us who have operated on many ectopic pregnancies in the face of shock or impending shock have always been amazed at the remarkable change in events and the rapid response to intra-

venous fluids and whole blood once the "hole in the dike has been plugged."

In **Case 196**, again a high degree of suspicion is essential in establishing a diagnosis of abdominal pregnancy even though the infrequency alone often precludes it in the differential diagnosis of bleeding at term. An x-ray revealed the head in "upper iliac fossa." This alone is suspicious and the diagnosis of abruptio placenta without the benefit of pelvic examination to me implies that any other procedure carried out by the attending physician would be subject to scrutiny and criticism. The choice of spinal anesthesia in the face of profound anemia and impending shock is not a good one. Removal of the placenta should be avoided and when it must be done, the use of tamponade with packs, a long forgotten practice, may sometime be life-saving.

In the foregoing instance, I must agree with the dissenter that early diagnosis might have changed the entire chain of events and that the maternal death might have been preventable.

Therapeutic Attack on Problem Of Diabetic Retinopathy

A new flavonoid, CVP (citrus vitamin P) had no beneficial effect on diabetic retinopathy in 33 patients. Minor improvement in retinal status occurred in 27 per cent of the patients. This rate of improvement is the same as that previously reported after many different therapies, and probably represents spontaneous variation in the course of this disease.

Late vascular damage has become the most important unsolved clinical problem in diabetes. Therapy with diet and insulin has preserved diabetic persons from early death due to coma, and delivered them to a fate of blindness and death in uremia.

Therapeutic attack on the problem of diabetic retinopathy is going forward on two main fronts. The first is based on the presumed role of pituitary and adrenal hormones. Recent experience with 9-a-fluoro-21-desoxy-Medrol, a steroid devoid of antiphlogistic or metabolic activity in man except for suppression of adrenocorticotropin production, offers some hope that an effective pituitary suppressant may be at hand.

The second therapeutic attack on diabetic vasculopathy is based on the premise that the basic abnormality is a derangement in lipid metabolism. Studies are currently under way to evaluate the therapeutic effect of polyunsaturated "essential" fatty acids, and preliminary results are said to be encouraging.—P. M. Brickley, M. D., et al., Santa Barbara: *California Med.*, 90:1, January, 1959.

Optimal Eye Care

A Report on Preventable Blindness

WILLIAM H. HAVENER, M. D.

A BLIND EYE is a serious loss to both patient and community. Awareness of the preventable nature of a significant portion of this blindness should help in reducing the incidence of such tragedies.

The goal of elimination of preventable blindness will not be reached until every patient with persistent eye symptoms realizes he should consult a competent medical physician. The symptoms of refractive error closely simulate the early symptoms of blinding eye disease, those of serious general bodily illnesses, or even those of mental illness. Study of case histories of preventable blindness all too often discloses the pattern of early symptoms disregarded by the patient, unrecognized by the nonmedical optometrist, and occasionally misinterpreted by a hurried physician.

Our aim should be to teach the warning symptoms of eye disease, proper eye care, and first aid principles applicable to eye injury. The following outlines may be helpful in such teaching.

(A) The seven eye danger signals for which a medical physician should be consulted are:

1. Persistent *redness* of the eye.
2. Continuing *discomfort* or pain about the eye, especially following injury.
3. Disturbances of vision
 - (a) Trouble seeing *near* or *distance*.
 - (b) *Fogginess* of vision, or *rainbow* colored halos around lights.
 - (c) Loss of *side vision*.
 - (d) Persistent *double vision* (seeing two things when there is really only one).
 - (e) Sudden development of many *floating spots* before the eyes.
4. *Crossing* of the eyes, especially in children.
5. *Growths* on eye or eyelids, or opacities visible in the normally transparent parts of the eye.
6. Continuing *discharge*, crusting, or tearing of the eyes.
7. *Pupil* irregularities (unequal size in the two eyes or distorted shape).

(B) How often should eyes be checked?

1. Whenever one of the seven eye danger signals appear, at any age.
2. At birth (to detect malformations, injuries, and infections).
3. Between 4 and 5 years of age (to detect "lazy eyes," which occur in 2 per cent of children and must be treated before school age.)
4. Every 5 years after the age of 40 (because

The Author

● Dr. Havener, Columbus, is on the attending staff at University Hospital, and Acting Chairman, Department of Ophthalmology, The Ohio State University College of Medicine.

by far the highest incidence of blindness is in older age groups.

5. As often as your own medical physician recommends (For example, annual checks of eye pressure is necessary after the age of 40 if cases of glaucoma occur in your family).

(C) First aid in eye injury

1. Chemical eye burns (acids, caustics, poisons).

Wash immediately with plain water, and continue for at least 15 minutes. Pour the water right into the open eye. Do not go to a doctor or anywhere else until the eye has been washed thoroughly for *at least 15 minutes*.

2. Wounds penetrating into the eyeball.

Do not touch these eyes in any way! Seek medical care as an immediate emergency. If possible, cover the eye with an out-curved metal shield which will protect against any accidental pressure on the eye.

3. Bleeding from the eye or eyelids.

Let it bleed! The eyeball itself may be damaged if pressure is applied to stop bleeding.

4. Foreign body or scratch on the clear cornea.

Do not rub your eye or pick at it. This must be treated with sterile instruments and protected against infection by antibiotics. See your medical doctor promptly.

5. Foreign particles on the conjunctiva (white of the eye). If this is easily seen, it may be carefully picked out with something clean. Do not use a dirty handkerchief. Do not touch the clear cornea! If removal is successful and the eye is perfectly comfortable and sees well, no further treatment is necessary.

6. "Black eye."

See your medical doctor to be certain the eyeball itself has not been damaged.

Every patient with persistent eye complaints deserves a medical eye examination.

A Clinicopathological Conference

Edited Under the Auspices of the Ohio Society of Pathologists

CHARLES BLUMSTEIN, M. D., *President*

Presentation of Case

THIS 63 year old white woman was admitted to the University Hospital, Columbus, Ohio, because of pain in the knees, ankles, wrists, fingers, back and occiput. About six years ago the patient noted some pain, redness and swelling in the right knee followed by similar manifestations in the left knee. She had also noted involvement of wrists, fingers, back, shoulders and elbows. Treatment with gold afforded no relief. She was treated with salicylates for several years, but six months prior to admission she developed petechiae on the arms and salicylates were discontinued. She also received 100 mg. of cortisone daily for one year. At this time she was also given a low-salt diet with potassium supplement. Three weeks prior to admission she was unable to walk without help and complained of pain in the thighs. Polyuria and polydipsia had been noted for the past one and a half years. Her blood pressure always remained at normal levels.

Physical Examination

Blood pressure was 130/80, pulse 80, respirations 18, and temperature 99°F. The patient was in acute distress with joint pain. She had Cushingoid facies. Examination of the neck revealed muscle spasm posteriorly with limitation of motion in all directions. Examination of the lungs revealed transient basilar rales which cleared after coughing. The heart was normal in size. There was a Grade I apical systolic murmur which was not transmitted.

Examination of the joints revealed swelling, heat and redness in both knees with fluid and marked crepitation upon movement. There was atrophy of the calf muscles in both legs, redness over both ankles and pain in the right ankle. Both hands were badly crippled. The wrists were in ulnar deviation. The skin of the legs and hands was smooth, glossy and atrophic. Nodules were palpated just below the left elbow on the extensor surface. There were also numerous petechiae over the flexor aspects of both forearms. The remainder of the physical examination was within normal limits.

Laboratory Data

The peripheral blood count, platelet count, clotting and bleeding time and bone marrow biopsy

Presented by

- Luther M. Keith, M. D., Columbus, and
 - Emmerich von Haam, M. D., Columbus.
- Edited by Dante G. Scarpelli, M. D., Columbus.

were normal. Sedimentation rate (Wintrobe) was 50. The serum sodium was 146 mEq., potassium 3.2 mEq. and chlorides 107 mEq. The blood and spinal fluid serologic tests were negative for syphilis. The serum antistreptolysin titer was 50 units. Urine examination revealed a trace of sugar, many white blood cells, occasional red blood cells, many amorphous crystals and numerous bacteria.

Roentgenographic Data

X-Ray examinations revealed mild pulmonary emphysema, arthritic changes in the cervical spine, osteoporosis and sclerosis of the entire spine, pelvic bones, ankles, knees, elbows, carphalangeal articulations and in some of the carpal bones. There were also cystic changes of the adjacent bones with swelling of the soft tissues of the wrists. A cholecystogram showed the presence of gallstones. An upper gastrointestinal series was essentially normal and no intrinsic filling defect or ulcer was demonstrated.

Hospital Course

The patient was treated with ACTH with some subjective improvement. She remained afebrile. Later the ACTH was discontinued and the patient was started on Butazolidine,[®] with no improvement. The doses of Butazolidine were reduced and the patient felt better but was unable to walk. She was also started on erythromycin. She became occasionally nauseated but had no epigastric pain. Later, a rash consisting of round erythematous patches with raised edges and depressed centers appeared over the axillae, groins, chest, buttocks and arms with some purpura on the left forearm. The patient was again started on ACTH.

Four weeks after admission the patient developed a fever of 102°F., and complained of sore throat and recurrence of joint complaints. She had an injected pharynx, hot knees and elbows and the persistence of the rash over the buttocks. The blood urea nitrogen was 53 mg. at that time. Urine culture revealed *Escherichia coli*. Following

this the patient was again afebrile, the rash cleared and she was more comfortable. The blood urea nitrogen rose to 67 mg. She was started on Gantrisin.[®] There was slight diarrhea. The patient was treated with intravenous fluids and subsequently the blood urea nitrogen fell to 35 mg. A few days later 25 mg. of hydrocortone was injected into each knee joint. A few days after this the patient was placed on salicylate therapy. She improved objectively and subjectively.

In the sixth week of her hospital stay her hemoglobin fell from 11 to 4 Gm. No active bleeding had been noted and no blood loss had been suspected previously. Examination revealed minimal epigastric tenderness. The guaiac test on the stool was strongly positive. The white blood count was 3,800 with 75 per cent neutrophils; the platelet count was 155,000. The prothrombin was 57.5 per cent, and the blood urea nitrogen had risen to 76.5 mg. ACTH was discontinued while the salicylate therapy was maintained and a transfusion of whole blood was given. The hemoglobin rose to 10.4 Gm. The patient was digitalized and treated with Pro-Banthine.[®] X-Ray examination of the abdomen revealed a prepyloric ulcer. Two days later the patient developed a low-grade fever, diarrhea and tenderness of the abdomen. Bowel sounds were present. The abdomen was tympanitic and markedly tender throughout with rebound tenderness.

The patient was transferred to the Surgical Service and on exploratory laparotomy 3000 to 4000 cc. of clear yellow fluid was encountered. No ulcer was found in the stomach or duodenum, but there was induration in the region of the pylorus. The liver was normal; the gallbladder contained stones but was thin-walled. The entire colon was markedly edematous. Shortly after the operation the patient's pulse rose to 120 and her blood pressure dropped to 90. She was given multiple blood transfusions, serum albumin and Levophed.[®] Despite these measures she ran a downhill course, required a tracheotomy, was placed in a respirator, and expired approximately eight hours after the operation. The length of her hospital stay was 55 days.

Clinical Discussion

DR. KEITH: I think this patient presents predominantly a medical disease with some interesting potentially surgical complications. I think perhaps we can summarize most of her illness and the complaints for which she was treated over a long period of time by saying that she was a 63 year old white female with a history of arthritic symptoms starting at the age of 53, occurring initially

in one, and shortly after, the other knee. The course of the disease was long, progressive and largely refractory to the entire gamut of arthritic therapy. Her therapy prior to admission included gold, salicylates and cortisone, and her course was complicated on at least one occasion by petechiae on the forearms. Apparently an acute exacerbation with inability to walk and general deterioration in her condition prompted hospitalization 55 days before her ultimate demise.

After admission the patient was initially treated with ACTH, for which Butazolidine was later substituted, but subsequently ACTH was again given until her episode of bleeding occurred. Salicylate was instituted prior to the discontinuance of ACTH and prior to the onset of the bleeding episode. Four weeks after admission her temperature rose to 102 and this was accompanied by an exacerbation of the arthritis and the appearance of an erythematous rash. The urine culture was positive for *E. coli*. About this time both Gantrisin and erythromycin were administered.

Iatrogenic Ulcer

In the sixth week of her hospitalization there was evidence of considerable blood loss. The stools gave a strongly positive guaiac test and allegedly an antral ulcer was found on upper gastrointestinal x-ray series. Her hemoglobin fell to 4 Gm. but promptly responded to transfusion, without any clear-cut information being obtained as to the source of the bleeding. Pro-Banthine was given apparently because of the bleeding. I think this was rather useless because this ulcer was more than likely iatrogenic, unavoidably so, with the large doses of salicylates, Butazolidine and in addition long periods of treatment with cortisone and ACTH which she received. Thus an ulcerogenic complication of her medical treatment would be a distinct possibility. Pro-Banthine was probably useless because the stimulation of gastric secretion by these drugs is not through vagal intervention.

Peritonitis?

Two days later the patient developed severe diarrhea, abdominal distention, tenderness and rebound tenderness and tympany, but there was preservation of bowel sounds. The presence or absence of pneumoperitoneum was not established, but this is a remote possibility. We would be markedly interested in the appearance of the stools as a result of her diarrhea and in what a stool smear or culture at that time would have shown. These acute abdominal symptoms and findings prompted a surgical consultation and it was apparently agreed that the patient should be explored. Her acute abdominal symptoms simulated

peritonitis, and in the presence of a recently diagnosed gastric ulcer I presume they thought it had perforated. Of the operative findings described in the protocol, probably the most significant was the markedly edematous colon. Following operation the patient's course was catastrophically downhill with tachycardia and refractory shock.

True Rheumatoid Arthritis?

To speculate and project some of these findings a bit further, first of all, I am curious as to whether this patient had true rheumatoid arthritis. The evidence certainly suggests that she had. We know that certain chronic inflammatory gastrointestinal lesions are complicated by an arthritic-like syndrome such as this woman showed. Admittedly it is usually not such an extensive deforming arthritis. However, the fact that it began in the knees is suggestive of the arthritic complications of regional ileitis and ulcerative colitis.

The next thing that is of interest because of the petechiae, which may or may not be a complication of the salicylate therapy, is whether this woman may have had hypersplenism of the type usually referred to as Felty's syndrome. This sometimes accompanies rheumatoid arthritis, particularly in middle-aged females who have had the disease for several years. On one or two occasions she had a leukopenia. It is not mentioned whether or not she had splenomegaly, but we know that the characteristic symptoms of Felty's syndrome in addition to the arthritis are anemia, weakness and susceptibility to various types of infection, which this woman certainly had. It may be that the rash, the sore throat, and the bouts of urinary infection were a complication of Felty's syndrome. The issue here is somewhat beclouded by the ACTH and cortisone, which are considered to be good therapy for the peripheral blood changes of Felty's syndrome.

Pseudomembranous Enterocolitis

I have already implied the probable etiology of the ulcer and I don't think we need to pursue that further. The other thing that intrigues me, and apparently the person who suggested exploration in this case, was the onset of acute abdominal symptoms shortly after the diagnosis of a gastric ulcer was made and following the apparent gastrointestinal hemorrhage. I think it would be logical to assume that it might be a perforated ulcer, but there are certain controversial data that would tend to indicate otherwise.

It is not often that you find the far-advanced distention, tympany, tenderness and rebound tenderness in a full-blown peritonitis and yet have active bowel sounds. This woman had many things

in her background, as well as the physical findings, to substantiate the diagnosis of pseudomembranous enterocolitis. First of all, what is the background for this catastrophic complication which may occur to patients in the hospital? Although it usually follows surgery, it can occur in other illnesses. We find most commonly a period of hypotension or shock and a recent period of administration of antibiotics that after the intestinal flora, resulting in a predominance of staphylococcus overgrowth, and at least in this case cortisone and ACTH may have exerted an additional influence.

This woman had a background of hemorrhage, prolonged administration of antibiotics, and there is an indirect implication that she may have been in shock or at least hypotensive during her episode of bleeding. I think this patient's initial physical findings, her terminal acute illness plus her operative findings and postoperative course would tend to incriminate pseudomembranous enterocolitis as the most likely single cause of death.

Clinical Diagnosis

If I were to list all the clinical diagnoses involved, I think I would list them as follows:

1. Rheumatoid arthritis, probably primary but possibly secondary to ulcerative colitis, or regional enteritis.
2. Collagen disease (scleroderma or periarteritis nodosa) because of some of the data included here and also its simulation of arthritis.
3. Felty's syndrome as a hypersplenic complication of arthritis.
4. Pyelonephritis, based on her urinary findings.
5. Gastric ulcer, which would explain the radiographic findings and her subsequent bleeding.
6. Cholecystitis and cholelithiasis.
7. Pseudomembranous enterocolitis as an acute terminal complication.

Pathologic Diagnosis

1. Acute necrotizing pseudomembranous enterocolitis.
2. Recent pre- and post-pyloric peptic ulcers.
3. Rheumatoid arthritis.
4. Acute pyelonephritis.

Pathologic Discussion

DR. VON HAAM: That was an excellent discussion of a difficult case, Dr. Keith. At autopsy the patient appeared well-nourished. She had a tracheotomy. The joint disease in the sternoclavicular joint was investigated and showed changes compatible with osteoarthritis. However, there were typical rheumatoid changes in the wrists.

There were hydrothorax and hydropericardium, which indicate that she was in failure. Her heart was small, brown and flabby. The lungs were edematous. This was probably secondary shock and heart failure.

The spleen, liver and pancreas appeared grossly normal, the gallbladder contained three gallstones. We found two ulcers, one in the stomach and one in the duodenum. The gastric ulcer was acute and deep, the duodenal ulcer was more chronic and had a fibrous base. Neither showed evidence of recent hemorrhage. The ileum was soft and edematous.

The greatest change was found in the colon. This showed a pseudomembranous colitis which was characterized by a green-black necrotic slough which covered the mucosa. This involved the entire colon and in some areas the lumen was filled with a hemorrhagic jelly-like material. The kidneys were small and the surface was finely granular. On cross section several 1-3 mm. pale yellow nodules were found in the cortex and medulla.

Microscopic Examination

Sections through the colon and the lower ileum showed necrosis and hemorrhage of the mucosa through its entire thickness with a pseudomembrane of fibrin, necrotic cells and bacteria. There was a paucity of leukocytes. A Gram stain showed large masses of gram-positive cocci incorporated into the pseudomembrane. Sections through the heart showed extensive myocardial edema and eosinophilic myocardial muscle fiber degeneration with extensive nuclear pyknosis. There was cytologic evidence of depressed adrenal cortical function secondary to the steroid therapy. Microscopic sections of the kidneys showed both an acute and chronic pyelonephritis. In addition the kidney showed a metastatic abscess filled with staphylococci but without a surrounding leukocytic infiltration.

We feel then that we are dealing with a case of pseudomembranous enterocolitis as first described by Kramer¹ in 1948. The etiology of this disease is as yet unsettled. However, all these cases show a common background of prolonged antibiotic therapy superimposed on an episode of shock. It has been suggested that these two factors act synergistically to precipitate this grave disease. The period of shock does not have to be a prolonged one; even transient periods of hypotension influence the production of this lesion. That may explain why this is more frequently observed in patients following surgery.

Her cardiac changes are attributable to the hypovolemia and electrolyte disturbances coincident to the massive necrotizing colitis. Lesions of the heart muscle in potassium deficiency can result in severe disturbances of the heart function.² I be-

lieve therefore that this patient suffered from pseudomembranous enterocolitis which resulted in severe electrolyte and fluid balance deficits, causing myocardial failure. Steroid therapy may have further complicated the picture by inhibiting the inflammatory response.³ This case occurred several years ago. Dr. Keith, you no longer have any fatalities from this complication, do you? You recognize it now?

DR. KEITH: I think we were misled in this case and in several others by this complication, which can simulate acute abdominal situations requiring surgical intervention. However, this is best managed conservatively. The clue of diagnostic value in this disease is the occurrence of an acute abdomen with a simultaneous paradoxical diarrhea which has the characteristics of the rice-water stools of cholera. A Gram stain of a simple rectal swab or stool swab will usually show an overgrowth of staphylococci. It may take as much as four hours from the onset of symptoms to the appearance of positive stools. Many patients will require large amounts of intravenous fluids, blood and serum albumin to maintain both plasma volume and electrolyte balance. The thing I would like to leave with you is that this is a very rapidly progressive, fulminant disease which if not recognized and treated rapidly is inevitably fatal.

References

1. Kramer, I. R. H.: Fatal Staphylococcal Enteritis Developing During Streptomycin Therapy by Mouth. *Lancet*, 2:646-647, 1948.
2. McAllen, P. M.: Myocardial Changes Occurring in Potassium Deficiency. *Brit. Heart J.*, 17:5-14, 1955.
3. Creditor, M. C.; Bevans, M.; Murdy, W. L., and Ragan, C.: The Effect of ACTH on Wound Healing in Humans. *Proc. Soc. Exp. Biol. and Med.*, 74:245-247, 1950.

Postgastrectomy Syndrome

Gastric surgery which by-passes or sacrifices the pylorus commonly produces a chain of uncomfortable symptoms which occur shortly after meals.

Satisfactory medical treatment of the dumping symptoms is based on dietary manipulation. Sweets, fluids, and milk products are avoided with meals, especially if their volume is large. Rest in the reclining position is advised after an unavoidably large meal. Small frequent feedings are preferable, especially in the early postoperative period.

It is felt that apparent spontaneous improvement of the patient with the postgastrectomy syndrome usually reflects a process of self-education. By trial and error the patient eventually learns to omit dietary items which are followed by dumping symptoms. The physician who understands the physiologic mechanisms of this postgastrectomy syndrome can often lead his patients quickly to a remission of these troublesome symptoms.—J., Walker Butin, M. D., Wichita: *J. Kansas M. Soc.*, 60:1, January, 1959.

OMI Expands Professional Relations . . .

Ohio's Blue Shield Plan Names Dr. Dooley To Do Liaison Work Between The Company and Medical Societies, Hospital Staffs and Other Groups

THE PHYSICIANS' RELATIONS program of Ohio Medical Indemnity has been stepped up with the appointment of a full-time director of professional relations. He is Dr. R. Dean Dooley, Dayton practicing physician and a member of OMI's Board of Directors for nine years. Dr. Dooley is giving up his private practice to assume his new duties.

In announcing the appointment of Dr. Dooley, OMI's president, Dr. H. M. Clodfelter pointed out that the expansion of coverage and contracts has necessitated a better understanding by physicians of the purposes, activities and benefits of OMI. "We were fortunate indeed to secure the full-time services of a physician so well qualified for this position," Dr. Clodfelter stated. In addition to his service on the Board of Trustees of OMI, Dr. Dooley has been currently serving as vice-president and as chairman of the Executive Committee.



Dr. Dooley

Dr. Dooley is presently planning a series of get-together conferences with County Medical Societies and with hospital staffs to discuss the OMI program. He will be glad to have officers of local groups contact him for specific engagements. Nelson Warner, who has been in the Claims Department of OMI for the past 10 years has been named assistant to Dr. Dooley and will be assigned the job of telling the profession about the technicalities of OMI activities.

Dr. Dooley's qualifications in professional relations are further emphasized by the fact that he is well founded in medical organization work and in hospital staff activities. For 18 years he has been a delegate from the Montgomery County Medical Society to the Ohio State Medical Association House of Delegates and since 1957 has been a member of The Council, representing the Second District.

While practicing in Dayton, Dr. Dooley was a member of the staffs of various Dayton hospitals and past chief-of-staff of Miami Valley Hospital.

He is a graduate of the University of Cincinnati College of Medicine. Active in civic affairs, he has served on the Board of Directors of the Southwestern Ohio Blue Cross, on the board of the Community Chest in his area, the Dayton Metropolitan Health Council and the Dayton Social Hygiene Society.

He is a past-president of the Montgomery County Medical Society, former chairman of the Section on Obstetrics and Gynecology of the OSMA and past chairman of the Judicial and Professional Relations Committee of the State Association.

Dr. Dooley is married and has two sons and four grandchildren. He will make his home in Columbus and will direct his activities from the home office of Ohio Medical Indemnity, at 3770 North High Street.

Ohio Academy of General Practice Names New Executive Secretary

R. Robert Wilson, Columbus, was named Executive Secretary of the Ohio Academy of General Practice and took over his duties in mid-February.

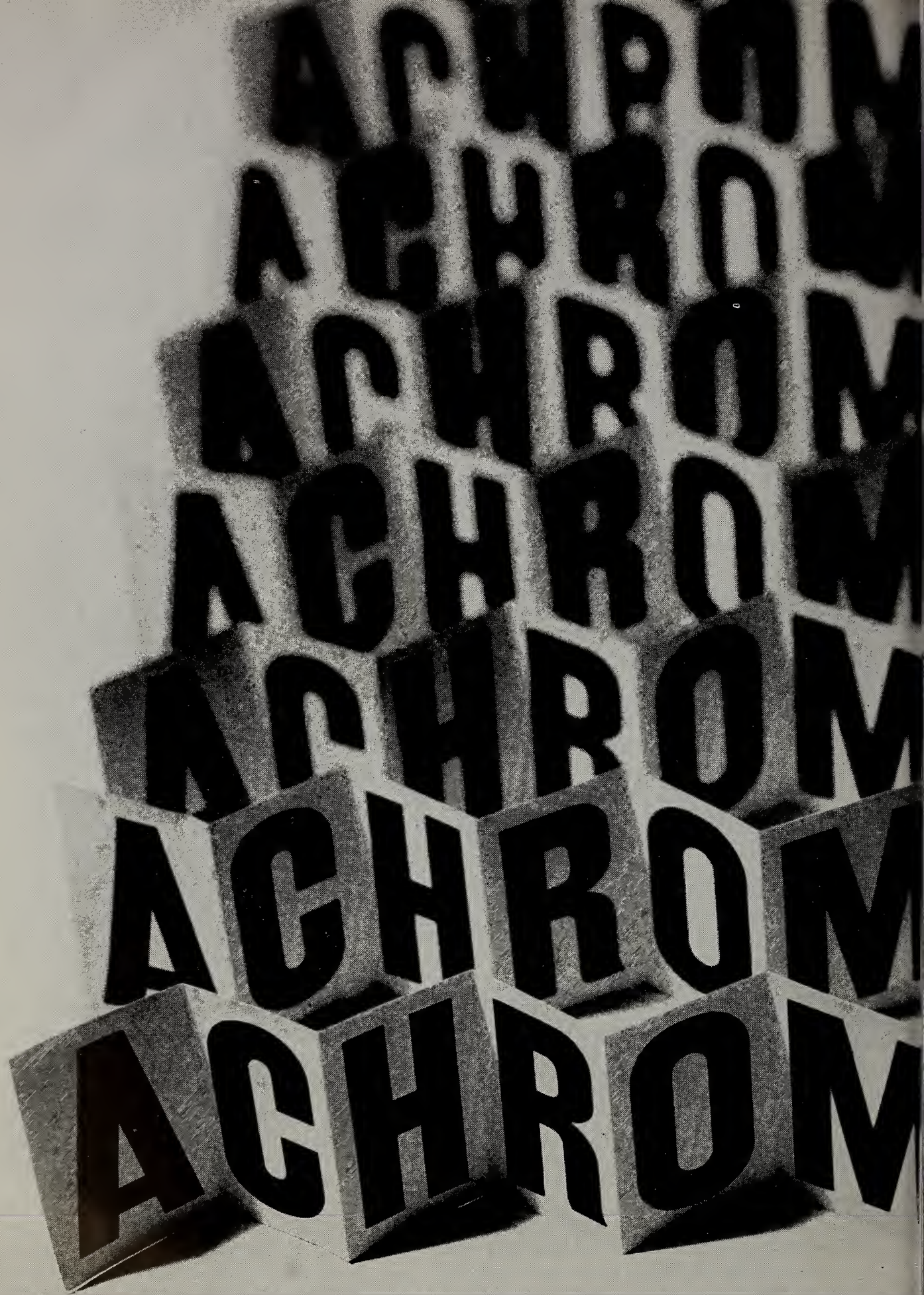
A native of Mt. Vernon, Mr. Wilson is a graduate of Ohio University and took graduate work at Ohio State University. He comes to the Academy from a post with the Columbus & Southern Ohio Electric Company as supervisor of its public service activities.

The new executive secretary succeeds the late David J. Byrnes who died on February 5 after filling the Academy position only since January, 1958.

The new OAGP headquarters office is at 1500 W. Third Ave., Columbus.

During the week beginning June 15 the second annual Refresher Course in Diagnostic Roentgenology will be held at the Cincinnati General Hospital. Details may be obtained from Dr. Benjamin Felson, X-Ray Department, Cincinnati General Hospital, Cincinnati 29, Ohio.

The United States Section, International College of Surgeons, has formed the Section on Surgery of Trauma as a successor to the Section on Occupational Surgery.



Announcing

The Official Program

for the



1959 ANNUAL MEETING
Ohio State Medical Association
COLUMBUS

Tuesday - Friday April 21 - 24

JOINT ENDEAVORS on the part of three co-operating organizations will add unique interest to the 1959 Annual Meeting program. The Ohio State Heart Association and the Ohio Division of the American Cancer Society are presenting the first day's programs. Ohio State University College of Medicine will climax the schedule of events by presenting the final day's program in celebration of its 125th anniversary. All sessions will be co-ordinated to make a four-day diversified program for members of the Association.

Time and Place: Tuesday, Wednesday, Thursday and Friday, April 21, 22, 23 and 24. Scientific programs, exhibits and other features will be in the Veterans Memorial Building, 300 West Broad Street in Columbus. The Annual Banquet and meetings of the House of Delegates are scheduled in the Neil House, 41 South High Street.

Registration: Headquarters will be in the West Entrance Lobby, ground floor of the Exhibit Hall, Veterans Memorial Building. Registration hours are 8:30 a. m. to 5:00 p. m. each day except Friday when the hours will be 8:30 a. m. to 3:00 p. m. Admission to all sessions and to the exhibits will be by badge secured at time of registration.

Those eligible to register are members of the Ohio State Medical Association (who should present 1959 Membership Cards at time of registration); physicians from other states who are

members of their respective state medical associations; residents, interns, medical students, nurses, health workers, and other guests who are presented at Registration Headquarters by members. The Woman's Auxiliary will provide registration for its members and others who are eligible to attend Auxiliary sessions.

Specialty Section Programs: Many Specialty Sections are conducting programs on Wednesday and Thursday and will have much in store for physicians in all branches of practice. In several instances two or more Specialty Sections have scheduled combined programs, broadening the range of interest in discussions. Consult daily charts for time and place.

Out-of-State Guest Speakers: Outstanding physicians from other states have accepted invitations to participate in the program. In many instances these guests are scheduled to speak on two or more occasions. Consult the program for names and subjects. Photographs of most of these guests are included.

General Sessions: Subjects and speakers at General Sessions were selected because of broad interest to physicians in various branches of practice. These sessions are scheduled so that no conflicting programs will interfere with those who wish to attend.

Scientific Exhibits: Scientific investigators and physicians whose clinical studies warrant special attention will present their findings in graphic form. Members of the sponsoring teams will be on hand to discuss significant points with physicians. Ample time has been provided throughout the program for frequent visits to these exhibits.

Technical Exhibit: Here will be a common meeting ground for physicians with detail men. Leading pharmaceutical and other supply houses will have skilled teams on hand to present the latest developments in their respective fields. Physicians will find these exhibits an inspiring source of information. Consult the program for breaks during which members will have ample time to visit these exhibits.

House of Delegates: The policy-making body of the State Association meets twice during the Annual Meeting. First session is on Monday evening, April 20, beginning with dinner. The second session is on Thursday morning, beginning with breakfast. Both meetings are in the Neil House. Participation in House of Delegates proceedings is reserved for those who attend in an official capacity. However, any member of the Association is welcome to attend. The dinner and breakfast also are for officials.

The Woman's Auxiliary: The ladies will hold their annual convention concurrently with that of the Association. Sessions are scheduled in the Deshler-Hilton Hotel. Board meetings will be held on Monday with the main session starting on Tuesday morning.

Annual Banquet: Wednesday evening, April 22, has been reserved for this event during which members and their ladies will enjoy dinner, music, dancing and entertainment. Tickets at \$7.50 each will be available by mail before the meeting and during the meeting at Registration Headquarters. The banquet will be in the Neil House.

How To Use This Program: First turn to the "time and place" charts, pages 367 to 371; then refer to the chronological program which follows for details as to speakers, subjects, and other data.

SCHEDULE OF EVENTS

MONDAY, APRIL 20

TIME	EVENT	PLACE
6:00 P. M.	OSMA HOUSE OF DELEGATES DINNER AND BUSINESS SESSION	Grand Ballroom, Mezzanine Floor Neil House

SCHEDULE OF EVENTS

TUESDAY, APRIL 21

(All sessions at the Veterans Memorial Building unless otherwise indicated.)

8:30 A. M.	REGISTRATION OPENS	West Entrance Lobby, Exhibit Hall Ground Floor
9:00 A. M.	OPENING OF SCIENTIFIC AND TECHNICAL EXHIBITS	Exhibition Hall Ground Floor
9:10 A. M.	GENERAL SESSION (Program sponsored and presented by Ohio Division, Inc., American Cancer Society)	Main Auditorium First Floor
9:10 to 9:15 A. M.	ADDRESS OF WELCOME Arthur G. James, M. D., Columbus President, Ohio Division, Inc., American Cancer Society	
9:15 to 10:45 A. M.	"Treatment of Uterine Cancer" (Panel Discussion)	
10:45 to 11:15 A. M.	RECESS FOR TOUR OF EXHIBITS	
11:15 to 11:45 A. M.	"Thyroid Cancer"	
11:45 A. M. to 12:15 P. M.	"Control of Pain in the Cancer Patient"	
12:15 to 1:30 P. M.	RECESS	

OSU Medical Students Given Special Incentive for Friday Sessions

All four classes of medical students at the Ohio State University College of Medicine will be dismissed Friday, April 24, so undergraduates may attend Annual Meeting sessions at the Veterans Memorial Building, Dr. Charles A. Doan, dean of the Medical College, announced.

Special provisions will be made to permit interns and residents to attend sessions of particular interest to them and to visit the exhibits.

Scientific and Technical Exhibits Are Outstanding Features

No small part of the 1959 Annual Meeting is the display of Scientific and Education Exhibits; also the Technical Exhibits, all of which are located in the Veterans Memorial Building for convenient viewing. Experience from previous meetings indicates that physicians spend much time in this area of the meeting place, an excellent witness to their value. Ample time has been provided during the meeting for visits to the Exhibits. Plan to visit them frequently.

SCHEDULE OF EVENTS

TUESDAY, APRIL 21

(All sessions at the Veterans Memorial Building unless otherwise indicated.)

TIME	EVENT	PLACE
1:30 P. M.	GENERAL SESSION (Program sponsored and presented by Ohio Division, Inc., American Cancer Society)	Main Auditorium First Floor
1:30 to 2:00 P. M.	"Leukemia in Childhood"	
2:00 to 2:30 P. M.	"Should the Cancer Patient Be Told?"	
2:30 to 3:00 P. M.	RECESS FOR TOUR OF EXHIBITS	
3:00 to 5:00 P. M.	"Cancer of the Gastrointestinal Tract" (Panel Discussion)	

SCHEDULE OF EVENTS

TUESDAY, APRIL 21

(All sessions at the Veterans Memorial Building unless otherwise indicated.)

2:00 P. M.	GENERAL SESSION (Program sponsored and presented by the Ohio State Heart Association)	Assembly Hall, Veterans Wing, First Floor
2:00 to 3:00 P. M.	"Hypertension" (Panel Discussion)	
3:00 to 3:30 P. M.	RECESS FOR TOUR OF EXHIBITS	
3:30 to 5:00 P. M.	CONTINUATION OF PANEL DISCUSSION	

All-Doctor Glee Club Will Entertain at Annual Banquet

When doctors go in for a bit of show business, that's news. And when doctors undertake to entertain doctors, you can be sure that enjoyment will come out of it for all. Forty-two members of the Montgomery County Medical Society have formed a Glee Club which has gained considerable recognition. This group, under the direction of Dr. W. J. Lewis, will entertain doctors and their ladies after the Banquet. See accompanying page about the banquet and directions as to how to order tickets.

SCHEDULE OF EVENTS

WEDNESDAY, APRIL 22

(All sessions at the Veterans Memorial Building unless otherwise indicated.)

TIME	EVENT	PLACE
8:30 A. M.	REGISTRATION	West Entrance Lobby, Exhibit Hall Ground Floor
9:00 to 9:30 A. M.	TOUR OF EXHIBITS	Exhibition Hall Ground Floor
9:30 to 11:00 A. M.	COMBINED SESSION SECTION ON GENERAL PRACTICE SECTION ON INTERNAL MEDICINE SECTION ON SURGERY	Assembly Hall Veterans Wing, First Floor
9:30 to 11:00 A. M.	SECTION ON NERVOUS AND MENTAL DISEASES	Room G-20 Ground Floor
9:30 to 11:00 A. M.	SECTION ON OPHTHALMOLOGY	Lower Mezzanine Lounge
9:30 to 11:00 A. M.	SECTION ON UROLOGY	Room G-14 Ground Floor
11:00 to 11:30 A. M.	RECESS FOR TOUR OF EXHIBITS	
11:30 A. M. to 12:30 P. M.	CONTINUATION OF SECTION MEETINGS	
2:15 P. M.	OHIO CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS	Rooms 203-204 Veterans Wing, Second Floor
2:00 P. M.	OHIO PSYCHIATRIC ASSOCIATION	Room G-20 Ground Floor
2:00 to 3:00 P. M.	GENERAL SESSION "What's New?"	Assembly Hall Veterans Wing, First Floor
3:00 to 3:30 P. M.	RECESS FOR TOUR OF EXHIBITS	
3:30 to 5:00 P. M.	GENERAL SESSION "The Prevention and Treatment of Rheumatic Fever" "Malignant Diseases of Children"	Assembly Hall Veterans Wing, First Floor
7:30 P. M.	ANNUAL BANQUET	Grand Ballroom Mezzanine Floor Neil House

SCHEDULE OF EVENTS

THURSDAY, APRIL 23

(All sessions at the Veterans Memorial Building unless otherwise indicated.)

TIME	EVENT	PLACE
8:30 A. M.	REGISTRATION	West Entrance Lobby, Exhibit Hall Ground Floor
8:30 A. M.	COMPLIMENTARY BREAKFAST FOR MEMBERS OF THE HOUSE OF DELEGATES, TO BE FOLLOWED BY FINAL BUSINESS SESSION	Grand Ballroom Mezzanine Floor Neil House
9:00 to 9:30 A. M.	TOUR OF EXHIBITS	Exhibition Hall Ground Floor
9:30 to 11:00 A. M.	CONFERENCE ON LABORATORY MEDICINE (Sponsored by Committee on Laboratory Medicine of OSMA)	Rooms 206-207 Veterans Wing, Second Floor
9:30 to 11:00 A. M.	COMBINED SESSION SECTION ON ANESTHESIOLOGY SECTION ON OBSTETRICS AND GYNECOLOGY	Assembly Hall Veterans Wing, First Floor
9:30 to 11:00 A. M.	SECTION ON INDUSTRIAL MEDICINE	Main Auditorium First Floor
9:30 to 11:00 A. M.	SECTION ON NEUROLOGICAL SURGERY	Room G-14 Ground Floor
9:30 to 11:00 A. M.	COMBINED SESSION SECTION ON OTORHINOLARYNGOLOGY SECTION ON RADIOLOGY	Lower Mezzanine Lounge
9:30 to 11:00 A. M.	COMBINED SESSION SECTION ON PEDIATRICS SECTION ON PHYSICAL MEDICINE	Room G-20 Ground Floor
11:00 to 11:30 A. M.	RECESS FOR TOUR OF EXHIBITS	
11:30 A. M. to 12:30 P. M.	CONTINUATION OF MORNING SESSIONS	
2:00 to 3:00 P. M.	GENERAL SESSION "Food Faddism"	Assembly Hall Veterans Wing, First Floor
3:00 to 3:30 P. M.	RECESS FOR TOUR OF EXHIBITS	
3:30 to 5:00 P. M.	GENERAL SESSION "Trauma"	Assembly Hall Veterans Wing, First Floor

SCHEDULE OF EVENTS

FRIDAY, APRIL 24

(All sessions at the Veterans Memorial Building unless otherwise indicated.)

TIME	EVENT	PLACE
8:30 A. M.	REGISTRATION	West Entrance Lobby, Exhibit Hall Ground Floor
9:00 to 9:30 A. M.	TOUR OF EXHIBITS	Exhibition Hall Ground Floor
9:30 to 10:30 A. M.	GENERAL SESSION (Program presented by Faculty and Alumni of Ohio State University College of Medicine)	Assembly Hall Veterans Wing, First Floor
9:30 to 10:00 A. M.	"Present Status of Intravenous Nutrition with Emphasis on Fat Emulsion"	
10:00 to 10:30 A. M.	"Unrecognized Urinary Bladder Distention Producing Large Bowel Compression and Obstruction"	
10:30 to 11:00 A. M.	RECESS FOR TOUR OF EXHIBITS	
11:00 to 11:30 A. M.	"Clinical Use of the Pump Oxygenator Without the Use of Donor Blood for Prime or Support During the Perfusion"	
11:30 A. M. to 12:00 Noon	"Modern Drug Therapy and Anesthesia"	
12:00 Noon to 12:30 P. M.	"Emerging Health Problems"	
12:30 to 2:00 P. M.	RECESS	
2:00 P. M.	GENERAL SESSION (Program presented by Faculty and Alumni of Ohio State University College of Medicine)	Assembly Hall Veterans Wing, First Floor
2:00 to 2:30 P. M.	"Tumors of the Testes"	
2:30 to 3:00 P. M.	"Recent Advances in the Study of Human Responses to Acceleration as Applied to Space Problem"	
3:00 to 3:30 P. M.	"Physicians' Responsibility in Transfusion"	
3:30 to 4:00 P. M.	"Duodenal Ulcer: Some Observations on Its Pathogenesis"	
4:00 to 4:30 P. M.	"Combined Surgical and Radiological Management of Primarily Inoperable Carcinomas of the Head and Neck"	
4:30 P. M.	ADJOURNMENT	

DELEGATES AND ALTERNATES

Counties	Delegates	Alternates
FIRST DISTRICT		
ADAMS	Kenneth C. Jee	
BROWN	John R. Donohoo	Charles H. Maly
BUTLER	Neil Millikin	Paul N. Ivins
	John A. Carter	John L. Bauer
CLERMONT	Carl A. Minning	C. F. Barber
CLINTON		
HAMILTON	Lester J. Bossert	Robert A. Bader
	Joseph G. Crotty	Charles D. Bahl
	Harry K. Hines	Chapin Hawley
	Richard B. Homan	Robert E. Howard
	Daniel V. Jones	Donald L. Jacobs
	William A. Moore	John H. Payne
	James D. Phinney	Carl F. Schilling
	Thomas J. Radley	Robert M. Sherman
	Stuart A. Schloss	Clayton R. Sikes
	Charles A. Sebastian	Robert W. Woliung
	Carl F. Vilter	Edward Woliver
HIGHLAND	J. Martin Byers	Will M. Hoyt
WARREN	D. Paul Ward	Thomas E. Fox

SECOND DISTRICT		
CHAMPAIGN	Isador Miller	V. R. Frederick
CLARK	Ray M. Turner	Elliott W. Schilke
	John M. Summers	Wm. H. Crays
DARKE	Maurice M. Kane	Ross M. Zeller
GREENE	Paul D. Espey	C. G. McPherson
MIAMI	John W. Gallagher	Robert L. Girouard
MONTGOMERY	Kenneth D. Arn	John R. Brown
	H. R. Cammerer	William H. Fries
	T. L. Light	Charles L. Kagay
	R. E. Pumphrey	S. L. Weinberg
PREBLE	C. J. Brian	J. R. Williams
SHELBY	George J. Schroer	J. W. Tirey

THIRD DISTRICT		
ALLEN	Dwight L. Becker	J. W. Zulliger
	Fred P. Berlin	John W. Burke
AUGLAIZE	Elizabeth Y. Kuffner	Edward E. White
CRAWFORD	D. D. Bibler	Edward C. Brandt
HANCOCK	L. H. Goodman	M. W. Feigert
HARDIN	W. J. Zaring	Wm. D. DeWar
LOGAN	Hobart L. Mikesell	Douglas W. Beach
MARION	Merritt K. Marshall	Daniel M. Murphy
MERCER	George H. McIlroy	Donald R. Fox
SENECA	Walter A. Daniel	Henry L. Abbott
VAN WERT	Edwin W. Burnes	A. C. Diller
WYANDOT	K. K. Solacoff	Allen F. Murphy

FOURTH DISTRICT		
DEFIANCE		
FULTON	Benjamin Reed	C. F. Murbach
HENRY	Thomas F. Tabler	Edwin C. Winzeler
LUCAS	E. F. Glow	Edward F. Ockuly
	J. Lester Kobacker	C. R. Marlowe
	A. J. Kuehn	S. W. Northup
	F. P. Osgood	Maurice A. Schnitker
	Frank F. A. Rawling	Oliver E. Todd
	Howard E. Smith	Wm. G. Henry
OTTAWA	Patrick Hughes	Paul K. Ridenour
PAULDING	D. E. Farling	K. A. Pritchard
PUTNAM	Milo B. Rice	Donald B. Lucas
SANDUSKY	A. C. Rini	Glenn H. Walker
WILLIAMS	Paul G. Meckstroth	John R. Riesen
WOOD	Roger A. Peatee	William H. Roberts

FIFTH DISTRICT		
ASHTABULA	S. A. Burroughs	S. L. Altier
CUYAHOGA	James O. Barr	W. F. Boukalik
	Joseph L. Bilton	D. B. Cameron
	F. L. Browning	E. H. Crawfis
	John H. Budd	Henry A. Crawford
	C. A. Colombi	Leon H. Dembo
	E. P. Coppedge, Jr.	Nicholas DePiero
	Eduard Eichner	Robert M. Eiben
	Eugene A. Ferreri	Wm. E. Forsythe
	John J. Grady	Wm. L. Huffman
	Harry A. Haller	Chester R. Jablonoski
	J. B. Hazard	Thomas D. Kinney
	Harris D. Iler	A. Macon Leigh
	Fred R. Kelly	J. D. Osmond
	John A. Kenney, Jr.	Russell P. Rizzo
	M. H. Lambright, Jr.	J. M. Rossen
	Paul A. Mielcarek	D. K. Spitler
	Philip J. Robecheck	Leo Walzer
	Paul J. Schildt	
	A. B. Schneider, Jr.	
	Leo H. Simoson	
	Edwin L. Smith	
GEAUGA	H. E. Shafer	W. C. Corey
LAKE	Benjamin S. Park	James G. Powell

Counties	Delegates	Alternates
SIXTH DISTRICT		
COLUMBIANA	John A. Fraser	Paul H. Beaver
MAHONING	G. E. DeCicco	R. R. Fisher
	Paul J. Mahar	J. J. McDonough
	H. P. McGregor	S. W. Ondash
	Asher Randell	C. C. Wales
PORTAGE	Myron W. Thomas	
STARK	Maurice F. Lieber	L. L. Dowell
	John R. Seesholtz	Mark G. Herbst
	J. B. Walker	D. E. Leavenworth
	Wm. White, Jr.	R. E. Tschantz
SUMMIT	Philip B. deMaine	Thomas S. Brownell
	Joseph J. Eckert	Devitt L. Gordon
	Arnold V. Gold	Arthur H. Loomis
	Walter A. Hoyt, Jr.	Bruce F. Rothmann
	Ross R. Zeno	
TRUMBULL	E. G. Caskey	J. M. Gledhill
	R. H. Ralston	S. J. Shapiro

SEVENTH DISTRICT		
BELMONT	B. C. Diefenbach	David Danenberg
CARROLL	Glenn C. Dowell	Robert C. Lanzer
COSHOCTON	J. C. Briner	Milton A. Boyd
HARRISON	George E. Henderson	Elias Freeman
JEFFERSON	Carl F. Goll	Warren G. Snyder
MONROE	Byron Gillespie	
TUSCARAWAS	Joseph W. Hamilton	R. E. Rinderknecht

EIGHTH DISTRICT		
ATHENS	D. R. Johnson	Carroll L. Sines
FAIRFIELD	J. L. Kraker	Chester P. Swett
GUERNSEY	James A. L. Toland	Robert A. Ringer
LICKING	Warren N. Koontz	Lawrence H. Miller
MORGAN		
MUSKINGUM	Earl R. Haynes	Joseph C. Greene
NOBLE	C. F. Thompson	F. M. Cox
PERRY	A. C. Lawrence	Ralph E. Herenden
WASHINGTON	Ford E. Eddy	Kenneth E. Bennett

NINTH DISTRICT		
GALLIA	Keith R. Brandeberry	W. Lewis Brown
HOCKING	Howard M. Boocks	C. T. Grattidge
JACKSON	A. R. Hambrick	C. C. Fitzpatrick
LAWRENCE	Harry Nenni	Gerard C. Geswein
MEIGS		
PIKE	Robert M. Andre	R. C. Netherton
SCIOTO	Wm. M. Singleton	W. E. Daehler
VINTON	H. D. Chamberlain	R. E. Bullock

TENTH DISTRICT		
DELAWARE	Tennyson Williams	A. R. Callander
FAYETTE	J. H. Persinger	M. H. Roszmann
FRANKLIN	Mel A. Davis	Drew J. Arnold
	Richard L. Fulton	Thomas R. Curran
	Edward W. Harris	Wiley L. Forman
	Philip B. Hardyman	Joseph C. Forrester
	Reuben B. Hoover	James C. Good
	Charles W. Pavey	John R. Huston
	Donald J. Vincent	Charles R. McClave
	Judson D. Wilson	William P. Smith, Jr.
KNOX	Henry T. Lapp	Raymond S. Lord
MADISON	Sol Maggied	
MORROW	Joseph P. Ingmire	Wm. S. Deffinger
PICKAWAY	E. L. Montgomery	Ned B. Griner
ROSS	Robert E. Swank	Ralph W. Holmes
UNION	Fred C. Callaway	E. J. Marsh

ELEVENTH DISTRICT		
ASHLAND	M. D. Shilling	R. Lee Schafer
ERIE	E. J. Meckstroth	C. J. Reichenbach
HOLMES	N. P. Stauffer	A. J. Earnery
HURON	Owen J. Nicholson	John V. Emery
LORAIN	James T. Stephens	John W. Newman
	George R. Wiseman	Henry E. Kleinhenz
MEDINA	Nevin J. M. Klotz	Richard W. Avery
RICHLAND	Charles F. Curtiss	Russell H. Barnes
	Harry Wain	P. O. Staker
WAYNE	Albert B. Huff	John M. Robinson

OFFICERS		
Pres.	George A. Woodhouse	Treas. Geo. J. Hamwi
Pres.-Elect, ..	Frank H. Mayfield	Past-Pres. ... Robert S. Martin

COUNCILORS		
District		District
First	Charles W. Hoyt	Seventh Robert E. Hopkins
Second	R. Dean Dooley	Eighth William D. Monger
Thrid	Floyd M. Elliott	Ninth Carter L. Pitcher
Fourth	Paul F. Orr	Tenth Edwin H. Artman
Fifth	George W. Petznick	Eleventh H. T. Pease
Sixth	Carl A. Gustafson	

MONDAY, APRIL 20

6:00 P.M.

HOUSE OF DELEGATES

COMPLIMENTARY DINNER FOR DELEGATES, ALTERNATES, OFFICERS AND COUNCILORS, TO BE FOLLOWED BY BUSINESS SESSION

Grand Ballroom, Mezzanine Floor,
Neil House

Call to order by James L. Henry, M. D., Grove City,
President of the Columbus Academy of Medicine.

Introduction of the President, George A. Wood-
house, M. D., Pleasant Hill.

Consideration of the minutes of the last Annual
Meeting (June, 1958, issue of *The Journal*).

Introduction of honored guests.

Report by President of Woman's Auxiliary—Mrs.
C. H. Bell, Mansfield.

Appointment of Reference Committees by the
President:

Credentials.

President's Address.

Resolutions.

Tellers and Judges of Election.

Report of Committee on Credentials of Delegates.

Nomination and Election of Committee on Nomi-
nations: (Nominations from the floor. One rep-
resentative [delegate] from each Councilor Dis-
trict. The committee shall report to the Sec-
ond Session, Thursday, 8:30 A. M., its recom-
mendations in the form of a ticket containing
nominees for offices, to be filled at this meeting
as required under the Constitution and Bylaws.)

Introduction of Resolutions:

(Resolutions must be introduced at this session
of the House of Delegates, referred to the
Reference Committees on Resolutions, and re-
ported back to the House of Delegates at the
Thursday morning session before any action can
be taken. All resolutions must be typewritten
and submitted in triplicate.)

Announcements of meeting places of Committee
on Nominations and Reference Committees by
chairmen of the committees.

Miscellaneous business.

Announcements of Annual Meeting events.

Recess.

Order Your Tickets Early For the Banquet

Remember that the Annual Banquet is an out-
standing feature of the Annual Meeting. Order
tickets early. On one of the accompanying pages
is a special coupon and instructions on how to get
your reservations in early.

TUESDAY, APRIL 21

8:30 A.M.

REGISTRATION OPENS

West Entrance Lobby, Exhibit Hall, Ground Floor
Veterans Memorial Building

9:00 A.M.

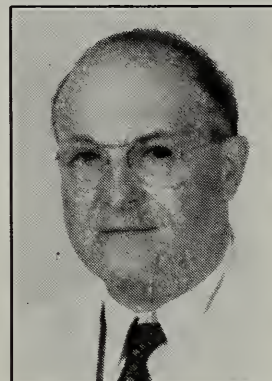
OPENING OF SCIENTIFIC AND TECHNICAL EXHIBITS

Exhibition Hall, Ground Floor
Veterans Memorial Building

Guest Participants



C. Bernard Brack, M. D.
Baltimore



Alexander Brunschwig,
M. D., New York

TUESDAY, APRIL 21

9:10 A.M.

GENERAL SESSION

Main Auditorium, First Floor
Veterans Memorial Building

Program sponsored and presented by the Ohio Division,
Inc., American Cancer Society.

THE PARTICIPANTS

C. Bernard Brack, M. D., Baltimore, Md., Asso-
ciate Professor of Gynecology, Johns Hopkins
University School of Medicine.

Alexander Brunschwig, M. D., New York, N. Y.,
Professor of Clinical Surgery, Cornell Univer-
sity Medical College, New York.

Gilbert H. Fletcher, M. D., Houston, Texas, Pro-
fessor of Radiology, The University of Texas
Postgraduate School of Medicine.

Edgar L. Frazell, M. D., New York, N. Y., Assist-
ant Professor of Clinical Surgery, Cornell Uni-
versity Medical College, New York.

Raymond W. Houde, M. D., New York, N. Y.,
Associate, Sloan-Kettering Institute for Cancer
Research.

Richard L. Meiling, M. D., Columbus, Professor
of Obstetrics and Gynecology, Ohio State Uni-
versity College of Medicine.

Presiding: William J. Flynn, M. D., Youngstown.
9:10 Welcome—Arthur G. James, M. D., Co-
lumbus, President, Ohio Division, Inc.,
American Cancer Society.

(Continued on Next Page)

Guest Participants



Michael R. Deddish, M.D.
New York



Samuel P. Harbison, M. D.
Pittsburgh

- 9:15 Treatment of Uterine Cancer (Panel Discussion)
Moderator: Dr. Meiling.
Members of Panel: Drs. Brack, Brun-
schwиг and Fletcher.
- 10:45 Recess for Tour of Exhibits.
- 11:15 Thyroid Cancer—Dr. Frazell.
- 11:45 Control of Pain in the Cancer Patient—
Dr. Houde.
- 12:15 Recess.

TUESDAY, APRIL 21

1:30 P. M.

GENERAL SESSION

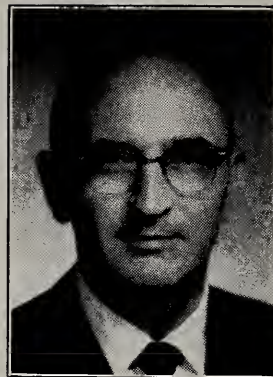
Main Auditorium, First Floor
Veterans Memorial Building

Program sponsored and presented by the Ohio Division,
Inc., American Cancer Society.

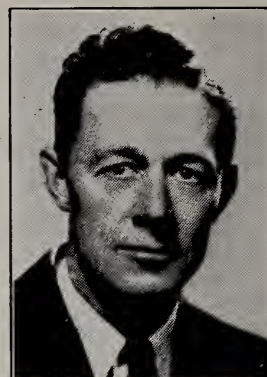
THE PARTICIPANTS

- Michael R. Deddish, M. D., New York, N. Y.,
Clinician, Sloan-Kettering Institute for Cancer
Research.
- Charles A. Doan, M. D., Columbus, Dean, Col-
lege of Medicine, Ohio State University.
- Samuel P. Harbison, M. D., Pittsburgh, Pa., Pro-
fessor and Chairman, Department of Surgery,
University of Pittsburgh School of Medicine.
- Edward S. Judd, Jr., M. D., Rochester, Minn.,
Professor of Surgery, Mayo Foundation of Uni-
versity of Minnesota.
- Edward M. Litin, M. D., Rochester, Minn., Uni-
versity of Minnesota Postgraduate School Faculty.
- Robert M. Zollinger, M. D., Columbus, Professor
and Chairman, Department of Surgery, Ohio
State University College of Medicine.
- Presiding: William J. Flynn, M. D., Youngstown.
- 1:30 Leukemia In Childhood—Dr. Doan.
- 2:00 Should The Cancer Patient Be Told?—
Dr. Litin.

Guest Participants



Gilbert H. Fletcher, M. D.
Houston



Edgar L. Frazell, M. D.
New York

- 2:30 Recess for Tour of Exhibits.
- 3:00 Cancer of the Gastrointestinal Tract
(Panel Discussion).
Moderator: Dr. Zollinger.
Members of Panel: Drs. Deddish, Har-
bison and Judd.
- 5:00 Adjournment.

TUESDAY, APRIL 21

2:00 P. M.

GENERAL SESSION

Assembly Hall, Veterans Wing, First Floor
Veterans Memorial Building

Program sponsored and presented by the Ohio State Heart
Association.

THE PARTICIPANTS

- Harriet P. Dustan, M. D., Cleveland, Member of
Staff, Cleveland Clinic Hospital.
- Harry Goldblatt, M. D., Cleveland, Professor of
Experimental Pathology, Western Reserve Uni-
versity School of Medicine.
- Arthur Grollman, M. D., Dallas, Texas, Profes-
sor and Chairman, Department of Experimental
Medicine, Southwestern Medical School of the
University of Texas.
- H. Mitchell Perry, Jr., M. D., St. Louis, Mo., Di-
rector, Hypertension Division, Department of
Internal Medicine, Washington University
School of Medicine.
- Maurice A. Schnitker, M. D., Toledo, Director of
Medicine, Chief of Medical Service, St. Vin-
cent's Hospital.
- Presiding: Dr. Schnitker.
- 2:00 Hypertension (Panel Discussion).
Moderator: Dr. Schnitker.
Members of Panel: Drs. Dustan, Gold-
blatt, Grollman and Perry.
- 3:00 Recess for Tour of Exhibits.
- 3:30 Continuation of Panel Discussion.
- 5:00 Adjournment.

WEDNESDAY, APRIL 22

8:30 A. M.

REGISTRATION

West Entrance Lobby, Exhibit Hall, Ground Floor
Veterans Memorial Building

9:00 to 9:30

TOUR OF EXHIBITS

WEDNESDAY, APRIL 22

9:30 A. M.

COMBINED SESSION

SECTION ON GENERAL PRACTICE

SECTION ON INTERNAL MEDICINE

SECTION ON SURGERY

Assembly Hall, Veterans Wing, First Floor
Veterans Memorial Building

This program for the combined session of the three sections was arranged by the following officers of the sections: William L. Hall, M. D., Columbus, Chairman, Burt E. Schear, M. D., Dayton, Secretary, Section on General Practice of Medicine; John A. Prior, M. D., Columbus, Chairman, Henry W. Ryder, M. D., Cincinnati, Secretary, Section on Internal Medicine; Richard W. Zollinger, M. D., Columbus, Chairman, and Jack W. Cole, M. D., Cleveland, Secretary, Section on Surgery.

THE PARTICIPANTS

Alvin J. Cummins, M. D., Memphis, Tenn., Associate Professor of Medicine, University of Tennessee.

Robert H. Ebert, M. D., Cleveland, John H. Hord Professor of Medicine, Western Reserve University School of Medicine.

John R. Hannan, M. D., Cleveland, Clinical Instructor in Radiology, Western Reserve University School of Medicine.

Frank H. Mayfield, M. D., Cincinnati, Chairman, Department of Neurosurgery, Christ Hospital and Good Samaritan Hospital.

Harvey J. Mendelsohn, M. D., Cleveland, Assistant Professor of Thoracic Surgery, Western Reserve University School of Medicine.

Thomas G. Skillman, M. D., Columbus, Assistant Professor of Medicine, Department of Endocrinology and Metabolism, Ohio State University College of Medicine.

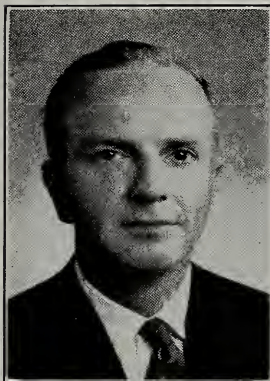
Max M. Zinninger, M. D., Cincinnati, Professor of Surgery, University of Cincinnati College of Medicine.

Presiding: Dr. Prior.

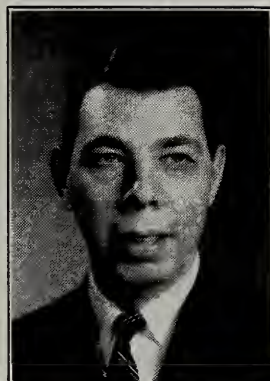
9:30 Pulmonary Emboli—Dr. Ebert.

9:45 Shoulder-Hand Syndrome—Dr. Mayfield.

Guest Participants



Edward S. Judd, Jr., M. D.
Rochester, Minn.



Edward M. Litin, M. D.
Rochester, Minn.



Raymond W. Houde, M.D.
New York



Arthur Grollman, M. D.
Dallas

10:00 Differential Diagnosis and Management of Gastric Ulcer (Panel Discussion).

Moderator: Dr. Cummins (internist).

Members of Panel: Dr. Hannan (radiologist) and Dr. Zinninger (surgery).

10:50 Election of Officers for 1960.

11:00 Recess for Tour of Exhibits.

Presiding: Dr. Zollinger.

11:30 Irritable Colon Syndrome—Dr. Cummins.

12:00 Hypercorticism—Dr. Skillman.

12:15 Dysphagia—Dr. Mendelsohn.

12:30 Adjournment.

Psychiatric Clinic Directors To Hold Luncheon April 22

The Ohio Association of Psychiatric Clinic Directors will hold a luncheon meeting at the Deshler-Hilton Hotel on Wednesday, April 22, starting at 12:15 P. M. Place of the luncheon will appear on the hotel bulletin board. Present officers of the organization are: Dorothy C. V. Heinz, M. D., Springfield, President; Walter A. Massie, M. D., Mansfield, President-Elect; Louis D. Kacalieff, M. D., Akron, Secretary-Treasurer.

WEDNESDAY, APRIL 22

9:30 A. M.

SECTION ON NERVOUS AND MENTAL DISEASES

Room G-20, Ground Floor
Veterans Memorial Building

Chairman.....J. Robert Hawkins, M. D., Cincinnati
Secretary.....E. H. Crawfis, M. D., Cleveland

THE PARTICIPANTS

Irwin N. Perr, M. D., Cleveland, Clinical Director, Cleveland Regional Treatment Center.

Louis Pillersdorf, M. D., Cleveland, Consulting Neuropsychiatrist, Lutheran Hospital.

John C. Saunders, M. D., Orangeburg, N. Y., Principal Research Scientist (Pharmacology), Research Facility, Rockland State Hospital.

9:30 Changes in Residence: Psychiatric Features—Dr. Pillersdorf.

10:15 Post-Traumatic Epilepsy and the Law—Dr. Perr.

11:00 Recess for Tour of Exhibits.

11:30 Clinical Implications of Neurochemistry—Dr. Saunders.

12:30 Adjournment.

WEDNESDAY, APRIL 22

9:30 A. M.

SECTION ON OPHTHALMOLOGY

Lower Mezzanine Lounge
Veterans Memorial Building

ChairmanJacob Moses, M. D., Columbus
Secretary.....Barnet R. Sakler, M. D., Cincinnati

THE PARTICIPANTS

James E. Bennett, M. D., Cleveland, Clinical Instructor of Ophthalmology, Western Reserve University School of Medicine.

J. M. B. Bloodworth, Jr., M. D., Columbus, Associate Professor of Pathology, Ohio State University College of Medicine.

William E. Hunt, M. D., Columbus, Assistant Professor of Neurosurgery, Ohio State University College of Medicine.

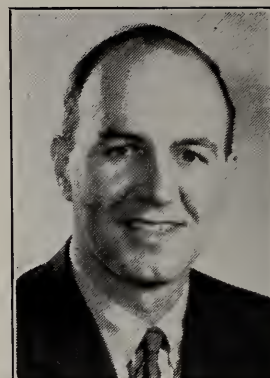
Albert M. Potts, M. D., Cleveland, Associate Professor, Ophthalmic Research, Western Reserve University School of Medicine.

David Volk, M. D., Cleveland, Diplomate, American Board of Ophthalmology.

Guest Participants



Alvin J. Cummins, M. D.
Memphis



John C. Saunders, M. D.
Orangeburg, N. Y.

Carolyn H. Ziegler, M. D., Columbus, Assistant Professor of Surgery (Anesthesia), Ohio State University College of Medicine.

9:30 Pathological and Experimental Findings in Diabetic Retinopathy—Dr. Bloodworth.

9:55 Neurosurgical Significance of the Ophthalmoplegias—Dr. Hunt.

10:15 Oculocardiac Reflex in Ophthalmic Surgery—Dr. Ziegler.

10:35 Cataract Extraction Following Parotid Duct Transplantation (Movie)—Dr. Bennett.

11:00 Recess for Tour of Exhibits.

11:30 Some Newer Aspects in the Explanation of the Toxic Amblyopias—Dr. Potts.

12:00 Clinical Uses of the Conoid Lenses—Dr. Volk.

12:30 Election of Officers for 1960.

12:40 Adjournment.

Jefferson Medical Alumni Reunion Scheduled Tuesday, April 21

A get-together on Tuesday, April 21, has been arranged for Alumni of Jefferson Medical College, their wives and guests who will attend the 1959 Annual Meeting of the Ohio State Medical Association in Columbus, April 21-24.

This year the meeting will be held again, in the University Club, 40 South Third Street, beginning with a social hour at 7:00 P. M. Dinner will be served at 8:00 P. M., followed by (short) speeches about Jefferson by faculty members. Reservations may be secured by calling Dr. Carey B. Paul, 466 North Cassady Avenue, Columbus, Chairman of Arrangements; CLebrook 8-2444.

WEDNESDAY, APRIL 22

9:30 A. M.

SECTION ON UROLOGY

Room G-14, Ground Floor
Veterans Memorial Building

Chairman.....John P. Smith, M. D., Columbus
Secretary.....G. R. Horton, M. D., Springfield

THE PARTICIPANTS

Gustav Eckstein, M. D., Cincinnati, Professor of Physiology, University of Cincinnati College of Medicine.

W. J. Kolff M. D., Cleveland, Associate Professor of Experimental Medicine, Frank E. Bunts Educational Institute, Cleveland Clinic Foundation.

James F. Schieve, M. D., Columbus, Associate Professor, Department of Medicine, Ohio State University College of Medicine.

- 9:30 Renal Physiology—Dr. Eckstein.
10:15 Evaluation of the Compromised Kidney—Dr. Schieve.
11:00 Recess for Tour of Exhibits.
11:30 The Treatment of Renal Failure—Dr. Kolff.
12:30 Election of Officers for 1960.

WEDNESDAY, APRIL 22

2:00 P. M.

OHIO PSYCHIATRIC ASSOCIATION

Room G-20, Ground Floor
Veterans Memorial Building

Chairman.....J. Robert Hawkins, M. D., Cincinnati
Secretary.....E. H. Crawfis, M. D., Cleveland

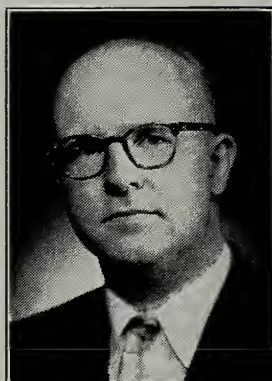
THE PARTICIPANTS

Mark Lefton, Ph. D., Columbus Psychiatric Institute and Hospital, Assistant Professor, Department of Sociology, Ohio State University.

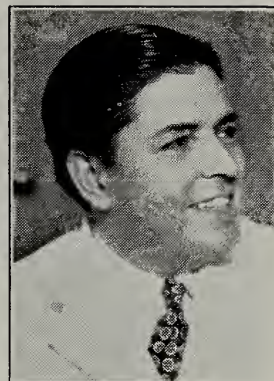
Henry Luidens, M. D., Superintendent, Lima State Hospital.

- 2:00 The Relation of Psychiatric Orientation to the Diagnosis of Mental Illness—Dr. Lefton.
2:30 110 Years of Experience with the M'Naghten Rule—Dr. Luidens.
3:00 Recess for Tour of Exhibits.
3:30 Business Session. Election of Officers for 1960 for Association and OSMA Section on Nervous and Mental Diseases.

Guest Participants



H. Mitchell Perry, Jr.,
M. D., St. Louis



Alejandro Aguirre, M. D.
Mexico

Ohio Doctors Invited to Pittsburgh PG Courses

Members of the Ohio State Medical Association are invited to enroll in a ten-week postgraduate course in clinical medicine being given at the U. S. Veterans' Administration Hospital, Pittsburgh, under the joint sponsorship of the University of Pittsburgh School of Medicine, the Allegheny County Medical Society and the Medical Society of the State of Pennsylvania.

Fifty-five hours in length, the course offers 55 hours of Category I credit, as approved by the American Academy of General Practice. It will be held on consecutive Wednesdays, March 18, through May 20. Hours are 9:30 a. m. to 4:00 p. m.

The course includes didactic presentations, conferences, panel discussions, demonstrations and case presentations on the various aspects of medicine and surgery. Some topics to be covered are diabetes, heart failure, head injuries, acute abdomen, cardiac arrhythmias, myocardial infarction, dermatosis, abortion, menstrual abnormalities, pediatrics, management of the peptic ulcer, molecular medicine and many other practical clinical and therapeutic problems.

For those who are interested in acquiring practical experience in procedures such as pelvic examinations, rhinologic treatments, cardiographic interpretations, rectal examinations, etc., special arrangements may be made after the course to attend well established and well supervised clinics at Magee, Montefiore and Children's Hospitals.

Requests for information should be directed to the Committee on Medical Education, 230 State Street, Harrisburg, Pennsylvania. Registration fees are \$65.00, payable with application. Checks should be made payable to the Medical Society of the State of Pennsylvania.

WEDNESDAY, APRIL 22

2:00 P. M.

GENERAL SESSION

Assembly Hall, Veterans Wing, First Floor
Veterans Memorial Building

THE PARTICIPANTS

- Alejandro Aguirre, M. D., Mexico, D. F., Professor of Pediatrics, National University of Mexico.
Charles H. Rammelkamp, M. D., Cleveland, Professor of Medicine, Western Reserve University School of Medicine.
John P. Storaasli, M. D., Cleveland, Associate Professor of Radiology, Western Reserve University School of Medicine.
Joseph F. Tomashefski, M. D., Columbus, Assistant Professor of Medicine and Physiology, Ohio State University College of Medicine.
R. B. Turnbull, M. D., Cleveland, Member of the Staff, Department of Surgery, Cleveland Clinic Foundation.
Warren E. Wheeler, M. D., Columbus, Professor of Pediatrics and Bacteriology, Ohio State University College of Medicine.
J. H. Williams, M. D., Columbus, Clinical Assistant Professor of Obstetrics and Gynecology, Ohio State University College of Medicine.
Presiding: A. Carlton Ernstene, M. D., Cleveland, Chairman, Committee on Scientific Work.

2:00 What's New?

In Hospital Staphylococci—Dr. Wheeler.

In the Clinical Use of Isotopes—Dr. Storaasli.

In the Treatment of Ulcerative Colitis—Dr. Turnbull.

In the Treatment of Pulmonary Emphysema—Dr. Tomashefski.

In Newborn Salvage—Dr. Williams.

3:00 Recess for Tour of Exhibits.

3:30 The Prevention and Treatment of Rheumatic Fever—Dr. Rammelkamp.

4:00 Malignant Diseases of Children—Dr. Aguirre.

5:00 Adjournment.

"No Margin for Error" is the title of a film produced by the Wm. S. Merrill Company, Cincinnati, in cooperation with the American Medical Association Law Department, the American Hospital Association and the American Bar Association. It deals with the cause and effect of human mistakes in the complex system of the modern hospital, and is one of a series of six films on medico-legal matters.

WEDNESDAY, APRIL 22

2:15 P. M.

OHIO CHAPTER

AMERICAN COLLEGE OF CHEST PHYSICIANS

Rooms 203-204, Veterans Wing, Second Floor
Veterans Memorial Building

Harvey J. Mendelsohn, M. D., Cleveland, President
F. G. Kravec, M. D., Youngstown, Sec'y.-Treas.

THE PARTICIPANTS

- W. R. Biddlestone, M. D., Cleveland, Department of Pulmonary Diseases, Cleveland Clinic and Senior Instructor in Pulmonary Diseases, Frank E. Bunts Institute of the Cleveland Clinic Foundation.
Robert Ebert, M. D., Cleveland, John H. Hord Professor of Medicine, Western Reserve University School of Medicine and Director of Medicine, University Hospitals of Cleveland.
William Molnar, M. D., Columbus, Associate Professor of Radiology, Ohio State University College of Medicine and Radiologist at University Hospital.
Philip C. Pratt, M. D., Columbus, Chief of Laboratories, Ohio Tuberculosis Hospital.
2:15 Coronary Arteriography—Dr. Molnar.
2:35 Pulmonary Capillary Proliferation Induced by Oxygen Inhalation—Dr. Pratt.
2:55 Differential Diagnosis of Diffuse Pulmonary Disease—Dr. Ebert.
3:15 Respiratory Acidosis—Dr. Biddlestone.

WEDNESDAY, APRIL 22

7:30 P. M.

ANNUAL BANQUET AND DANCE

Grand Ballroom, Mezzanine Floor
Neil House

Introduction of Officers and Councilors.

Introduction of Distinguished Guests.

Presentation of Plaques to Outgoing Councilors who have served maximum terms on The Council.

Fort Steuben Academy

The Fort Steuben Academy of Medicine met for dinner and a program on February 10 in Steubenville. The subject was "Gynecological Diseases in Adolescents and Children," and the speakers, Dr. Hugo Baum, Presbyterian-St. Luke's Hospital, Chicago; and Dr. Carl S. Bickel, Wheeling, West Virginia.

The Fifteenth Congress and Graduate Instructional Course in Allergy of the American College of Allergists will be held March 15-20 in San Francisco.

The 1959 Banquet

Wednesday, April 22; a Pause in a Busy Schedule; A Get-Together with Colleagues; an Evening of Entertainment for Doctors and Their Wives

A Pause in a Busy Schedule: Coming at the half-way point in a four-day program, the Banquet furnishes a social evening when physicians and their wives can relax and participate in an evening including good food, dinner music, entertainment and dancing.



A Get-Together with Colleagues: For many physicians this is the one day in the year when they can sit down with their out-of-town colleagues to discuss subjects of new and old interest. Many physicians in the past have remarked about the impact of spending an evening with colleagues from all parts of the State meeting socially in one group. The ladies, too, enjoy this opportunity to meet with their friends from other parts of the state.

An Evening of Entertainment: For the first time, many physicians will have an opportunity of hearing the Montgomery County Medical Society Glee Club. This group, believed to be the only all-M. D. group of singers in the country, has built up a unique reputation during the short time it has been organized. Following this feature of entertainment there will be an evening of dancing.

Order Tickets Now: Since this is primarily a social event, there will be a nominal charge of \$7.50 per person. This amount includes gratuities. Use the coupon below to order your tickets now.

Time and Place: The Banquet will be in the Main Ballroom of the Neil House, 41 South High Street, Columbus. The time is 7:30 p. m., Wednesday, April 22. Dancing will continue until 1 o'clock.



Order Tickets Now for the Annual Banquet

The Ohio State Medical Association
79 E. State Street, Columbus 15, Ohio

Send me tickets at cost of \$7.50 each for the Annual Banquet, Ohio State Medical Association, Wednesday, April 22, Neil House, Columbus.

(Check, payable to the Ohio State Medical Association, for total cost of tickets ordered, must accompany order.)

Name (Please Print)

Street City and Zone

THURSDAY, APRIL 23

8:30 A. M.

**HOUSE OF DELEGATES
COMPLIMENTARY BREAKFAST
FOR MEMBERS OF THE HOUSE OF
DELEGATES TO BE FOLLOWED BY
THE FINAL BUSINESS SESSION**

Grand Ballroom, Mezzanine Floor
Neil House

ORDER OF BUSINESS

Report of Committee on Credentials.

Consideration of unfinished business.

Reports of Reference Committees.

President's Address.

Resolutions.

Election of President-Elect. Nominations from the floor.

Report of Committee on Nominations:

(a) Nominations for The Council.

(Members of The Council are elected for two-year terms; terms of those representing the even-numbered districts expire in the odd-numbered years.) To be elected:

Second District—(Incumbent, R. Dean Dooley, M. D., Dayton.)

Fourth District—(Incumbent, Paul F. Orr, M. D., Perrysburg.) (Ineligible for re-election, having served the maximum time on The Council as provided in the Constitution and Bylaws of the Association.)

Sixth District—(Incumbent, Carl A. Gustafson, M. D., Youngstown.) (Ineligible for re-election, having served the maximum time on The Council as provided in the Constitution and Bylaws of the Association.)

Eighth District—(Incumbent, William D. Monger, M. D., Lancaster.)

Tenth District—(Incumbent, Edwin H. Artman, M. D., Chillicothe.) (Ineligible for re-election, having served the maximum time on The Council as provided in the Constitution and Bylaws of the Association.)

(b) Election of Delegates and Alternates to the American Medical Association—four Delegates and four Alternates to be elected, each for a two-year term starting January 1, 1960, in compliance with the Constitution

and Bylaws of the American Medical Association.

The following incumbent Delegates and Alternates will serve for the remainder of 1959, and they may be considered by the nominating committee for re-election for two-year terms starting January 1, 1960:

Paul A. Davis, M. D., Akron
(Delegate)

Edmond K. Yantes, M. D., Wilmington
(Alternate)

Carll S. Mundy, M. D., Toledo
(Delegate)

Paul F. Orr, M. D., Perrysburg
(Alternate)

L. Howard Schriver, M. D., Cincinnati
(Delegate)

Charles A. Sebastian, M. D., Cincinnati
(Alternate)

C. C. Sherburne, M. D., Columbus
(Delegate)

Richard L. Meiling, M. D., Columbus
(Alternate)

Because of an increase in the number of Ohio physicians affiliating with the American Medical Association, the Ohio State Medical Association will be entitled to another A. M. A. delegate in 1959, making the total Ohio representation, nine. For this reason, the House of Delegates will have to elect one delegate and one alternate for the calendar year, 1959, and one delegate and one alternate for a two-year term, starting January 1, 1960.

Installation of officers for 1959-1960.

Submission of committee appointments by the new President for confirmation by the House of Delegates.

Unfinished or new business.

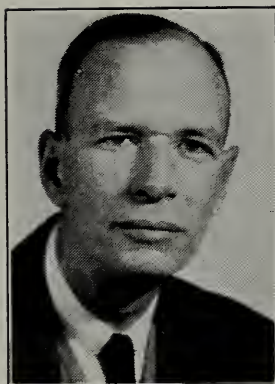
Adjournment.

**Emergency Telephone Service Will Be
Maintained by Columbus Academy**

The Columbus Academy of Medicine will maintain a local information booth and emergency telephone service in the Veterans Memorial Building during the times that program events are in progress. The special telephone number at the booth will be CA 4-3439. Physicians may wish to leave this number with their secretaries.

The physician also should leave information at his home and office as to which hotel he will be in for possible contact at other times. The information booth also will maintain a bulletin board on which names of physicians being called will be posted. Since it has been found impractical to page physicians in assembly halls or on the exhibit floor, members should consult this board frequently for pending calls.

Guest Participants



William K. Bannister,
M. D., Hartford, Conn.



Bradley Copeland, M. D.
Boston

THURSDAY, APRIL 23

8:30 A. M.

REGISTRATION

West Entrance Lobby, Exhibit Hall, Ground Floor
Veterans Memorial Building

9:00 to 9:30

TOUR OF EXHIBITS

THURSDAY, APRIL 23

9:30 A. M.

CONFERENCE ON LABORATORY MEDICINE

Rooms 206-207, Veterans Wing, Second Floor
Veterans Memorial Building

This Conference on Laboratory Medicine is sponsored by the Committee on Laboratory Medicine of the Ohio State Medical Association, which consists of the following members: Horace B. Davidson, M. D., Columbus, Chairman; Edward L. Burns, M. D., Toledo; John B. Hazard, M. D., Cleveland; Melvin Oosting, M. D., Dayton; Arthur E. Rappoport, M. D., Youngstown; William B. Smith, M. D., Zanesville; and Philip B. Wasserman, M. D., Cincinnati.

THE PARTICIPANTS

Bradley Copeland, M. D., New England Deaconess Hospital, Boston, Mass.

Marie Gilstrap, M. T. (ASCP), University Hospital, Columbus.

John Johnson, M. T. (ASCP), Miami Valley Hospital, Dayton.

John W. King, M. D., Cleveland Clinic, Cleveland.

Sister Mary Norbert, R. S. M., M. T. (ASCP) Our Lady of Mercy Hospital, Cincinnati.

Melvin Oosting, M. D., Miami Valley Hospital, Dayton.

Presiding: Dr. Davidson.

9:30 Medical Technology Training (Panel Discussion).

Moderator: Dr. Oosting.

Members of Panel: Sister Norbert, Mr. Johnson, Miss Gilstrap and Dr. King.

11:00 Recess for Tour of Exhibits.

11:30 Quality Control in the Laboratory—Dr. Copeland.

12:30 Adjournment.

THURSDAY, APRIL 23

9:30 A. M.

COMBINED SESSION

SECTION ON ANESTHESIOLOGY

SECTION ON OBSTETRICS AND GYNECOLOGY

Assembly Hall, Veterans Wing, First Floor
Veterans Memorial Building

This program for the combined session of the two sections was arranged by the following officers of the sections: Donald E. Hale, M. D., Cleveland, Chairman, Charles W. Hoyt, M. D., Cincinnati, Secretary, Section on Anesthesiology; Harry E. Ezell, M. D., Columbus, Chairman, Eduard Eichner, M. D., Cleveland, Secretary, Section on Obstetrics and Gynecology.

THE PARTICIPANTS

William K. Bannister, M. D., Hartford, Conn., Associate Anesthesiologist, Hartford Hospital.

Robert A. Hingson, Jr., M. D., Cleveland, Professor of Anesthesiology, Western Reserve University School of Medicine.

James E. Matson, M. D., Columbus, Instructor, Department of Surgery (Anesthesia), Ohio State University College of Medicine.

James M. McCord, M. D., Cincinnati, Assistant Professor, Department of Obstetrics, University of Cincinnati.

Howard P. Taylor, M. D., Cleveland, Associate Professor of Obstetrics and Gynecology, Frank E. Bunts Educational Institute.

J. H. Williams, M. D., Columbus, Clinical Assistant Professor of Obstetrics and Gynecology, Ohio State University College of Medicine.

Presiding: Dr. Hale.

9:30 Resuscitation of the Newborn Infant (Panel Discussion).

Moderator: Dr. Hingson.

Members of Panel: Drs. Bannister, Matson, McCord and Taylor.

11:00 Recess for Tour of Exhibits.

Presiding: Dr. Ezell.

11:30 Perinatal Mortality—Dr. Williams.

12:00 The Physiologic Effects of Asphyxia Neonatorum—Dr. Bannister.

12:30 Election of Officers for 1960.

Give Hotels a Break—If You Can't Attend, Cancel

Hotel rooms will be in demand during the Annual Meeting. Many doctors may have to find accommodations in outlying areas when they would much prefer to stay downtown. If you have a reservation and find that you can't attend, please cancel and make the room available for someone else.

"Did Not Show," written across a hotel reservation card means a dead loss to the hotel. It's a simple matter to cancel if the occasion arises.

THURSDAY, APRIL 23

9:30 A. M.

SECTION ON INDUSTRIAL MEDICINE

Main Auditorium, First Floor
Veterans Memorial Building

Chairman.....Paul A. Davis, M. D., Akron
Secretary.....Robert M. Andre, M. D., Waverly

THE PARTICIPANTS

- Wm. F. Ashe, M. D., Columbus, Professor and Chairman, Department of Preventive Medicine, Ohio State University College of Medicine.
Charles A. Doan, M. D., Columbus, Dean, Ohio State University College of Medicine.
A. G. Kammer, M. D., Pittsburgh, Pa., Professor and Head of Department of Occupational Health, Graduate School of Public Health, University of Pittsburgh.
W. Donald Ross, M. D., Cincinnati, Assistant Professor of Industrial Medicine and Associate Professor of Psychiatry, University of Cincinnati College of Medicine.
- 9:30 Remarks by Dr. Davis, the Chairman, and Dr. H. Lawrence, Cincinnati, President, Industrial Medical Association.
- 9:45 Preventive Psychiatry for Industrial Workers—Dr. Ross.
- 10:20 The Potential Dangers in Modern Industry to the Hematopoietic Organs—Dr. Doan.
- 11:00 Recess for Tour of Exhibits.
- 11:30 The Position of the Industrial Physician in Industrial Management—Dr. Kammer.
- 12:10 Carcinomas of Occupational Origin—Dr. Ashe.
- 12:30 Election of Officers for 1960.

THURSDAY, APRIL 23

9:30 A. M.

SECTION ON NEUROLOGICAL SURGERY

Room G-14, Ground Floor
Veterans Memorial Building

Chairman.....William A. Nosik, M. D., Cleveland
Secretary.....William E. Hunt, M. D., Columbus

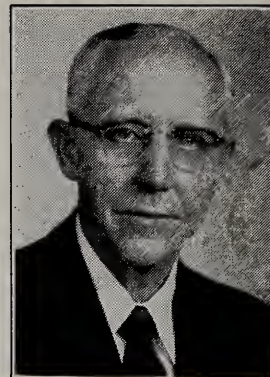
THE PARTICIPANT

- Eben Alexander, Jr., M. D., Winston-Salem, N. C., Professor of Neurosurgery and Head of Department of Neurosurgery, The Bowman Gray School of Medicine of Wake Forest College.
- 9:30 Hypothermia in the Management of Intracranial Aneurysms—Dr. Alexander.
- 10:15 Management of Myelomeningoceles—Dr. Alexander.
- 11:00 Recess for Tour Exhibits.
- 11:30 Discussion Period.
- 12:30 Election of Officers for 1960.

Guest Participants



Eben Alexander, Jr., M. D.
Winston-Salem



A. G. Kammer, M. D.
Pittsburgh

THURSDAY, APRIL 23

9:30 A. M.

COMBINED SESSION

SECTION ON OTORHINOLARYNGOLOGY

SECTION ON RADIOLOGY

Lower Mezzanine Lounge
Veterans Memorial Building

This program for the combined session of the two sections was arranged by the following officers of the sections: Sylvester C. Missal, M. D., Cleveland, Chairman, Richard H. Stahl, M. D., Cuyahoga Falls, Secretary, Section on Otorhinolaryngology; Paul D. Meyer, M. D., Columbus, Chairman, Daniel E. Wertman, M. D., Cleveland, Secretary, Section on Radiology.

THE PARTICIPANTS

- Charles M. Barrett, M. D., Cincinnati, Professor of Radiation Therapy, University of Cincinnati.
- John J. Conley, M. D., New York, N. Y., Clinical Professor of Otolaryngology, Columbia University College of Physicians and Surgeons.
- Matthew W. Elson, M. D., Columbus, Assistant Professor of Radiology, Ohio State University College of Medicine.
- Robert L. Garber, M. D., Mansfield, Director of Radiology, Mansfield General Hospital.
- Edward W. Harris, M. D., Columbus, Professor and Chairman of Department of Otolaryngology, Ohio State University College of Medicine.
- Julius W. McCall, M. D., Cleveland, American Board of Otorhinolaryngology.
- Thomas C. Pomeroy, M. D., Columbus, Associate Professor of Radiology, Ohio State University College of Medicine.
- Presiding: Dr. Missal.

9:30 Diagnosis and Treatment of Cancer of Cervical Esophagus, Larynx and Pharynx (Panel Discussion).

Moderator: Dr. Harris.

(Continued on Next Page)

Cancer of Larynx and Epiglottis—
Dr. McCall.

Cancer of Cervical Esophagus and
Pharynx—Dr. Conley.

X-Ray Diagnosis and Therapy—Dr.
Barrett.

X-Ray Therapy—Dr. Pomeroy.

10:50 Discussion Period.

11:00 Recess for Tour of Exhibits.

Presiding: Dr. Meyer.

11:30 The Surgical Treatment of Cancer of
the Ear and Temporal Bone—Dr.
Conley.

12:00 Radiotherapy for Recurrent Lymphoid
Tissue of Nasopharynx with Particu-
lar Reference to Recurrent Adenoid
Tissue after Adenoidectomy — Dr.
Garber.

12:15 Cholesteatoma—Dr. Elson.

12:30 Election of Officers for 1960.

THURSDAY, APRIL 23

9:30 A. M.

COMBINED SESSION

SECTION ON PEDIATRICS

SECTION ON PHYSICAL MEDICINE

Room G-20, Ground Floor
Veterans Memorial Building

This program for the combined session of the two sections was arranged by the following officers of the sections: Arthur H. Spreen, M. D., Cincinnati, Chairman, Charles Q. McClelland, M. D., Cleveland, Secretary, Section on Pediatrics; Richard D. Burk, M. D., Columbus, Chairman, Paul A. Nelson, M. D., Cleveland, Secretary, Section on Physical Medicine.

THE PARTICIPANTS

John E. Allen, M. D., Cincinnati, Assistant Professor of Pediatrics, University of Cincinnati College of Medicine.

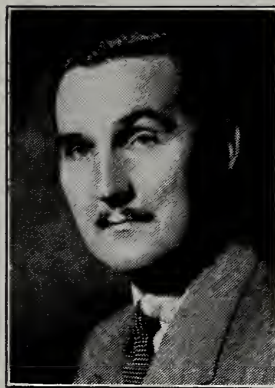
Richard F. Baer, M. D., Toledo, Chairman, Department of Physical Medicine and Rehabilitation, Children's Hospital of Toledo.

Ernest W. Johnson, M. D., Columbus, Assistant Professor, Physical Medicine and Rehabilitation, Ohio State University College of Medicine.

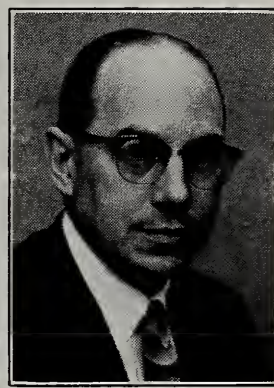
John Riepenhoff, M. D., Columbus, Assistant Professor, Department of Pediatrics, Ohio State University College of Medicine.

Jack H. Rubinstein, M. D., Cincinnati, Instructor, Department of Pediatrics, University of Cincinnati College of Medicine.

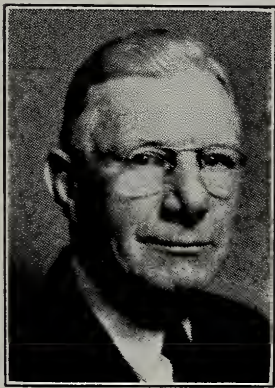
Guest Participants



John J. Conley, M. D.
New York



Chester A. Swinyard, M. D.
New York



Robert H. Kennedy, M. D.
New York



Oscar P. Hampton, Jr.,
M. D., St. Louis

Chester A. Swinyard, M. D., New York, N. Y., Associate Professor of Medicine and Physical Medicine, New York University College of Medicine.

Presiding: Dr. Burk.

9:30 Common Neurologic and Neuromuscular Diseases in Infants and Children (Panel Discussion).

Moderator: Dr. Rubinstein.

The Anatomical and Physiological Basis for Cerebral Palsy — Dr. Swinyard.

Early Detection of Cerebral Palsy in Infancy — Dr. Riepenhoff.

The Long Term Institutional Care of the Handicapped Child — Dr. Allen.

Instructing the Family in a Home-Care Program for the Handicapped Child — Dr. Baer.

11:00 Recess for Tour of Exhibits.

11:30 Continuation of Panel Discussion.

The Use of the Electromyogram as an Aid in the Diagnosis of Neuromuscular Diseases in Infancy — Dr. Johnson.

11:50 Discussion Period.

12:30 Election of Officers for 1960.

THURSDAY, APRIL 23

2:00 P. M.

GENERAL SESSION

Assembly Hall, Veterans Wing, First Floor
Veterans Memorial Building

THE PARTICIPANTS

E. Thomas Boles, Jr., M. D., Columbus, Assistant Professor of Surgery, Ohio State University College of Medicine.

Oliver Field, Chicago, Ill., Director, Bureau of Investigation, American Medical Association.

N. J. Giannestras, M. D., Cincinnati, Chairman, Ohio Committee on Trauma, American College of Surgeons.

Oscar P. Hampton, Jr., M. D., St. Louis, Mo., Assistant Professor of Clinical Orthopedic Surgery, Washington University School of Medicine.

Robert H. Kennedy, M. D., New York, N. Y., Former Professor of Clinical Surgery, New York University Postgraduate Medical School.

K. L. Milstead, Ph. D., Washington, D. C., Director, Division of Regulatory Management, Bureau of Enforcement, Food and Drug Administration.

Maye A. Russ, New York, N. Y., Director, Food, Drug and Cosmetic Division, National Better Business Bureau, Inc.

Warren E. Whyte, Chicago, Ill., Attorney, Law Division, American Medical Association.

Presiding: Maurice A. Schnitker, M. D., Toledo, Member, Committee on Scientific Work.

2:00 Food Faddism (Panel Discussion).

Moderator: Mr. Whyte.

Members of Panel: Mr. Field, Dr. Milstead and Miss Russ.

3:00 Recess for Tour of Exhibits.

3:30 Symposium on Trauma

(Sponsored jointly by the Ohio Committee on Trauma of the American College of Surgeons and the Ohio State Medical Association.)

Moderator: Dr. Giannestras.

The Establishment of the Triage System—Dr. Hampton.

The Care of the Multiple Injured Patient—Dr. Kennedy.

Trauma in Childhood—Dr. Boles.

5:00 Adjournment.

FRIDAY, APRIL 24

8:30 A. M.

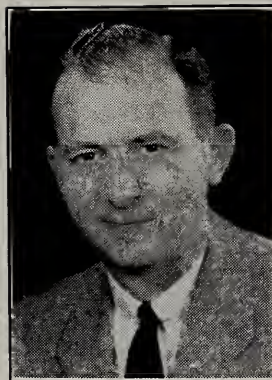
REGISTRATION

West Entrance Lobby, Exhibit Hall, Ground Floor
Veterans Memorial Building

9:00 to 9:30

TOUR OF EXHIBITS

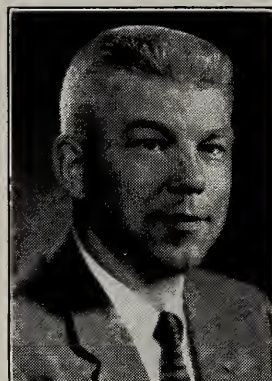
Guest Participants



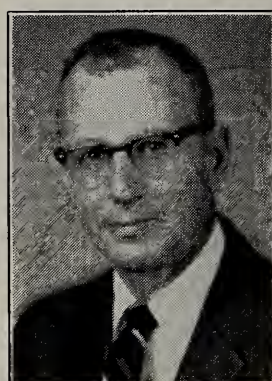
Oliver Field
Chicago



Maye A. Russ
New York



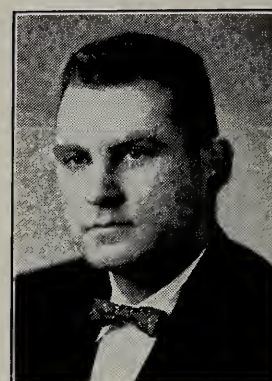
Warren E. Whyte
Chicago



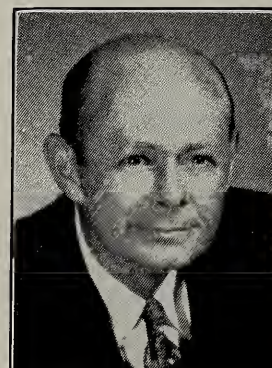
K. L. Milstead, Ph. D.
Washington, D. C.



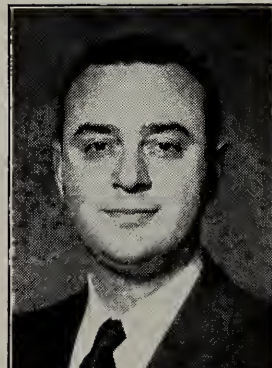
William Hamelberg, M. D.
Charleston, S. C.



Arnold B. Kurlander, M. D.
Washington, D. C.



Curtis P. Artz, M. D.
Jackson, Miss.



Maurice Galante, M. D.
San Francisco

Guest Participants



Herbert G. Shepler, M. D.
Seattle



Robert A. Moore, M. D.
Brooklyn, N. Y.

FRIDAY, APRIL 24

9:30 A. M.

GENERAL SESSION

Assembly Hall, Veterans Wing, First Floor
Veterans Memorial Building

Program presented by the Faculty and Alumni of Ohio State University College of Medicine.

THE PARTICIPANTS

Curtis P. Artz, M. D., Jackson, Miss., Associate Professor of Surgery, The University of Mississippi Medical Center.

William Hamelberg, M. D., Charleston, S. C., Professor and Chairman, Department of Anesthesiology, Medical College Hospital and Medical College of South Carolina.

Arnold B. Kurlander, M. D., Washington, D. C., Assistant Surgeon General, Deputy Chief, Bureau of Medical Services, Department of Health, Education and Welfare.

Wilford B. Neptune, Boston, Mass., Associate, Overholt Thoracic Clinic.

Jack Widrich, M. D., Miami Beach, Fla., Director of Radiology, Mount Sinai Hospital.

Presiding: Cyril T. Surington, M. D., Erie, Pa., President, Ohio State University College of Medicine Alumni Association.

9:30 Present Status of Intravenous Nutrition with Emphasis on Fat Emulsion—Dr. Artz.

10:00 Unrecognized Bladder Distention Producing Large Bowel Compression and Obstruction—Dr. Widrich.

10:30 - 11:00 Recess for Tour of Exhibits.

11:00 Clinical Use of the Pump Oxygenator Without the Use of Donor Blood for Prime or Support During the Perfusion—Dr. Neptune.

11:30 Modern Drug Therapy and Anesthesia—Dr. Hamelberg.

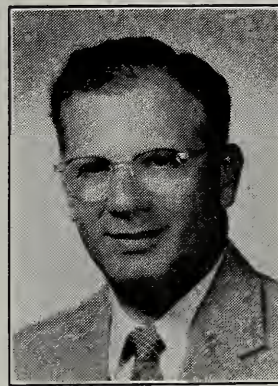
12:00 Emerging Health Problems—Dr. Kurlander.

12:30 Intermission.

Guest Participants



Wilford B. Neptune, M. D.
Boston



Jack Widrich, M. D.
Miami Beach

FRIDAY, APRIL 24

2:00 P. M.

GENERAL SESSION

Assembly Hall, Veterans Wing, First Floor
Veterans Memorial Building

Program presented by the Faculty and Alumni of Ohio State University College of Medicine.

THE PARTICIPANTS

C. Joseph DeLor, M. D., Columbus, Clinical Professor of Medicine, Director of Gastroenterology Division, Ohio State University College of Medicine, University Hospital.

Maurice Galante, M. D., San Francisco, Cal., Assistant Professor of Surgery, University of California School of Medicine.

Paul I. Hoxworth, M. D., Ph. D., Cincinnati, Associate Professor of Surgery and Director, Division of Hemotherapy, Department of Surgery, University of Cincinnati College of Medicine.

Robert A. Moore, M. D., Brooklyn, N. Y., Dean, College of Medicine, State University of New York College of Medicine.

Herbert G. Shepler, M. D., Seattle, Wash., Space Medicine Studies, Boeing Airplane Company; Captain, (MC) USN (retired).

Presiding: Charles A. Doan, M. D., Columbus, Dean, Ohio State University College of Medicine.

2:00 Tumors of the Testes—Dr. Moore.

2:30 Recent Advances in the Study of Human Responses to Acceleration as Applies to Space Problem—Captain Shepler.

3:00 Physicians' Responsibility in Transfusion—Dr. Hoxworth.

3:30 Duodenal Ulcer: Some Observations on Its Pathogenesis—Dr. DeLor.

4:00 Combined Surgical and Radiological Management of Primarily Inoperable Carcinomas of the Head and Neck—Dr. Galante.

4:30 Adjournment.

SCIENTIFIC AND EDUCATIONAL EXHIBITS

The Scientific and Educational Exhibits in the Exhibit Hall of the Veterans Memorial Building will be open daily from 9:00 A. M. to 5:30 P. M. on Tuesday, April 21, Wednesday, April 22, Thursday, April 23, and from 9:00 A. M. to 3:00 P. M. on Friday, April 24.

Following is a list of exhibits approved by the Committee on Scientific and Educational Exhibits prior to February 20. A number of applications are awaiting processing.

Cervical Carcinoma in Situ: The Role of Radical Conization

James S. Krieger, M. D., and Lawrence J. McCormack, M. D., Cleveland Clinic.

Treatment of Iron Deficiency: Past and Present

Nejdat Mulla, M. D., Youngstown.

Pelvic Floor Relaxation—Impressions in Oil

George B. Haydon, M. D., and Lester J. Bossert, M. D., University of Cincinnati College of Medicine.

Perforated Peptic Ulcers

Richard W. Zollinger, M. D., Carlos Andarso, M. D., Mount Carmel Hospital, Columbus.

Operative Ureteral Injuries

Wm. E. Forsythe, M. D., Lester Persky, M. D., University Hospitals, Cleveland.

Family Centered Obstetrics

Albert C. Lammert, M. D., Howard P. Taylor, M. D., Cleveland Clinic.

Problems of Sex Determination

Lester W. Martin, M. D., William K. Schubert, M. D., Virginia M. Esselborn, M. D., Benjamin H. Landing, M. D., University of Cincinnati College of Medicine and Children's Hospital, Cincinnati.

Restoration of Pinch in the Severely Injured Hand

John C. Kelleher, M. D., and James G. Sullivan, M. D., Toledo.

Anterior Spinal Fusion

A. W. Humphries, M. D., W. A. Hawk, M. D., Cleveland Clinic Foundation.

Radioactive Isotopes in Hematology

James S. Hewlett, M. D., George C. Hoffman, M. D., John D. Battle, Jr., M. D., Cleveland Clinic.

Pulmonary Disability Evaluation

J. F. Tomashefski, M. D., A. J. Christoforidis, M. D., R. H. Browning, M. D., Ohio Tuberculosis Hospital, Columbus.

Radioiodine for Diagnosis and Therapy of Hyperthyroidism Due to Adenomatous Goiter

Penn G. Skillern, M. D., Marvin Clamen, M. D., E. Perry McCullagh, M. D., Otto Glasser, Cleveland Clinic.

Maternal Mortality in Franklin County—A 10 Year Study; Maternal Health in Ohio—the OSMA State Study.

Richard L. Meiling, M. D., Anthony Ruppersberg, Jr., M. D., The Columbus Obstetric-Gynecologic Society. Committee on Maternal Health, Ohio State Medical Association.

Accidental Poisoning in Children

American Medical Association, Chicago, Ill.; Committee on Poison Control, Ohio State Medical Association.

Physician's Responsibility in Highway Accidents

American Medical Association, Chicago, Ill.; Committee on Traffic Safety, Ohio State Medical Association.

Nutrition Nonsense and Food Quackery

American Medical Association, Chicago, Ill.

Ohio State Pharmaceutical Association

Ohio State Pharmaceutical Association, Columbus.

Non-Medical Session of Ohio State Heart Association Scheduled

In addition to the scientific session of the Ohio State Heart Association scheduled as part of the OSMA Annual Meeting, there also will be a non-medical session. This program is scheduled at the Deshler Hilton Hotel, Broad and High Streets in Columbus. The time is 2 to 5 p. m. on Tuesday, April 21.

Two features are scheduled. The first is a presentation entitled, "Your Heart Association." T. Stenson White, Cleveland, will preside. The following persons will present the subject from the national, state and local level, respectively: Rome A. Betts, New York, "The American Heart Association"; Walter S. Page, Jr., Columbus, "The Ohio State Heart Association"; Mrs. Jerry H. Bruner, Cleveland, "The Chapter Heart Association."

The second feature is a panel discussion entitled "County Heart Committees and Councils." Samuel Cooper, Ph. D., Bowling Green, will be moderator with the following panel: Mrs. Robert Lewis, Perrysburg; Ward A. Riley, Lorain; Dan Martin, Greenville; and Mrs. Donald Domer, Georgetown.

TECHNICAL EXHIBITORS

Exhibition Hall, Ground Floor, Veterans Memorial Building

Open from 9:00 A. M. to 5:30 P. M. on Tuesday, Wednesday, and Thursday, April 21, 22, 23; and from 9:00 A. M. to 3:00 P. M. on Friday, April 24.

Exhibitor	Address	Booth No.	Exhibitor	Address	Booth No.
Abbott Laboratories, North Chicago, Ill.		56	Mueller, V., & Co., Chicago, Ill.		71
Aloe, A. S., Company, St. Louis, Mo.		68, 69	Mutual Benefit Life Insurance Company,		
Ames Company, Inc., Elkhart, Ind.		98	Newark, N. J.		96
Ayerst Laboratories, Arlington, Va.		1	Ohio Medical Indemnity, Inc., Columbus, O.		89
Baker Laboratories, Inc., The, Cleveland, O.		70	Organon, Inc., Orange, N. J.		23
Berghausen, E., Chemical Company, The,			Ortho Pharmaceutical Corporation, Raritan,		
Cincinnati, Ohio		44	New Jersey		19
Borchardt Company, Chicago, Ill.		91	Parke, Davis & Company, Detroit, Mich.		99
Borden Company, The, New York, N. Y.		50	Pfizer Laboratories, Brooklyn, N. Y.		52
Brewer & Company, Inc., Worcester, Mass.		37	Purdue Frederick Company, The, New York,		
Burroughs Wellcome & Co. (U. S. A.) Inc.,			New York		24
Tuckahoe, N. Y.		54	Rhinopto Company, The, Dallas, Texas		9
Cameron Surgical Instruments Company,			Roche Laboratories, Nutley, N. J.		83
Chicago, Ill.		8	Roerig, J. B., and Company, New York,		
Carnation Company, Los Angeles, Cal.		16	New York		36
Central Pharmacal Company, The, Seymour,			Rorer, William H., Inc., Philadelphia, Pa.		5
Indiana		11	Ross Laboratories, Columbus, Ohio		55
Coca-Cola Company, The, Atlanta, Ga.		60	Royal McBee Corporation, The, Columbus,		
Columbus Hospital Supply Co., Columbus, O.		75	Ohio		48
Columbus Pharmacal Company, The, Colum-			Sanborn Company, Waltham, Mass.		58
bus, Ohio		42	Sandoz Pharmaceuticals, Hanover, N. J.		21
Desitin Chemical Company, Providence, R. I.		27	Saunders, W. B., Company, Philadelphia, Pa.		25
Eaton Laboratories, Norwich, N. Y.		38	Schering Corporation, Bloomfield, N. J.		7
Emerson, J. H., Co., Cambridge, Mass.		12	Schieffelin & Co., New York, N. Y.		3
Encyclopaedia Britannica, Detroit, Mich.		97	Schmid, Julius, Inc., New York, N. Y.		81
Endo Laboratories, Richmond Hill, N. Y.		51	Sealy Mattress Company, Cleveland, Ohio.		88
Fischer, H. G. & Co., Franklin Park, Ill.		72	Searle, G. D., & Co., Chicago, Ill.		78
Fleet, C. B., Company, Inc., Lynchburg, Va.		57	Smith, Kline & French Laboratories, Phila-		
Fougera, E., & Co., Inc., Hicksville, N. Y.		33	delphia, Pa.		6
Freeman Manufacturing Company, Sturgis,			Squibb, E. R., & Sons, Division of Olin		
Michigan		63	Mathieson Chemical Corp., New York,		
Gallagher-Roach & Company, Columbus, O.		87	New York		14
Gerber Products Company, Fremont, Mich.		47	Stuart Company, The, Pasadena, Cal.		34
Great Books of the Western World, Grand			Swift & Company, Chicago, Ill.		26
Rapids, Mich.		13	Tailby-Nason Company, New York, N. Y.		90
Heinz, H. J., Company, Pittsburgh, Pa.		76	Testagar & Co., Inc., Detroit, Mich.		64
Holland-Rantos Co., Inc., New York, N. Y.		61	Turner & Shepard, Inc., Columbus, Ohio		2
Lederle Laboratories Division, American			U. S. Standard Products Co., Mount Prospect,		
Cyanamid Co., Pearl River, N. Y.		59	Illinois		29
Lilly, Eli, and Company, Indianapolis, Ind.		66	U. S. Vitamin Corporation, New York, N. Y.		65
Lippincott, J. B., Company, Philadelphia, Pa.		18	Upjohn Company, The, Kalamazoo, Mich.		77
Lloyd Brothers, Inc., Cincinnati, Ohio		80	Vercor & Co., Columbus, Ohio		4
Loma Linda Food Company, Arlington, Cal.		43	Warren-Teed Products Company, The, Co-		
Maico Hearing Service, Columbus		28	lumbus, Ohio		53
Massengill, S. E., Co., Bristol, Tenn.		49	Wendt-Bristol Co., The, Columbus, Ohio		45, 46
Mead Johnson & Company, Evansville, Ind.		79	Westwood Pharmaceuticals, Buffalo, N. Y.		15
Medco Products Co., Tulsa, Okla.		95	Winthrop Laboratories, New York, N. Y. ..		74
Medical Protective Company, The, Fort			Woche, Max, & Son Co., The, Cincinnati, O.		73
Wayne, Ind.		39			
Merck Sharp & Dohme, Div. of Merck &					
Co., Inc., Philadelphia, Pa.		41			
Merrell, Wm. S. Co., The, Cincinnati, Ohio		62			
Milex-Alpha Products, Morton Grove, Ill.		31			
Mosby, C. V. Company, The, St. Louis, Mo.		32			

More Resolutions . . .

Additional Proposals To Be Considered by House of Delegates at 1959 Annual Meeting, Filed With Columbus Office As Required in By-Laws

FOLLOWING are additional resolutions which will be considered by the House of Delegates at the 1959 Annual Meeting. The House will hold its first session at the Neil House Monday, April 20, at 6:00 P. M. when resolutions will be formally introduced by delegates. The second session of the House will be on Thursday, April 23, 8:30 A. M. at the Neil House.

These proposed resolutions were filed with the Executive Secretary prior to February 19. Therefore, they meet the 60-days deadline provided in Section 8 of Chapter 4 of the By-Laws of the Ohio State Medical Association.

Delegates desiring to present resolutions which were not filed with the Columbus Office on or before February 19 will have to obtain the consent of two-thirds of the delegates in attendance on April 20 in order to present their proposals.

A resolution from The Council recommending an increase of \$5.00 in the per capita dues of the Association, effective January 1, 1960, was published in the January issue of *The Journal*, having been filed with the Executive Secretary following its adoption by The Council on December 13, 1958.

Re: AAPS Essay Contest

(To be presented by Dr. Chas. W. Pavey,
Columbus)

WHEREAS, the House of Delegates of the OSMA has for several years approved the Essay Contest of the Association of American Physicians and Surgeons on the Advantages of Private Medical Care or The Advantages of The American System of Free Enterprise and

WHEREAS, many auxiliaries of the OSMA throughout the state have conducted such Essay Contests and

WHEREAS, continued acceptance of the contest by the auxiliaries is contingent upon approval by the House of Delegates and

WHEREAS, participation in such contests tends to teach the essayists the facts on these subjects

THEREFORE BE IT RESOLVED, that the House of Delegates of the OSMA reaffirm its approval of said essay contest.

Re: Protection in Athletics

(To be submitted on behalf of the Madison
County Medical Society)

WHEREAS, Professional Athletics, football especially, is causing a profound effect on Athletics (on coaches, on officials and on the athletes) especially at the High School level, and

WHEREAS, this effect is adding to the injury poten-

tial and causing an increasing number of unnecessary injuries, and

WHEREAS, this august body needs to continue its interest in protective and preventive measures,

BE IT HEREBY RESOLVED, that the Ohio State Medical Association use its offices to create a liaison between the Ohio State Medical Association and the Rules Committee of the Ohio State Athletic Association thus to be of medical assistance in the protective phase of rules interpretations.

Re: Sixty (60) Day Deadline for Resolutions

(To be submitted on behalf of the Madison
County Medical Society)

WHEREAS, tradition has always allowed the democratic method of introducing resolutions from the floor, annually only, and,

WHEREAS, tradition has always allowed that controversial or indecisive resolutions be referred to Council for further action, and,

WHEREAS, this august body is one of the few remaining active bodies propounding active democracy,

BE IT HEREBY RESOLVED, that last year's resolution number two (2) (which changed the Constitution By-Laws and caused a sixty (60) day deadline for resolutions) be revoked and that this section of the Constitution of the Ohio State Medical Association read as prior to the Ohio State Medical Association meeting of 1958 in essence, namely, that resolutions may be introduced from the floor of the House of Delegates.

Re: Indemnity Insurance

(To be presented by the Montgomery
County Medical Society)

WHEREAS, The pre-payment voluntary insurance plans are assuming an increasingly important role in determining the future course of organized medicine; and

WHEREAS, We believe the indemnity principle in pre-payment health insurance programs offers the best promise of serving the needs of our people; and

WHEREAS, The Council of the Ohio State Medical Association through the Board of Directors of the Ohio Medical Indemnity has steadfastly supported the indemnity philosophy; and

WHEREAS, The medical service committee of the Ohio State Medical Association has effectively expounded the position of the Ohio State Medical Association in its negotiations with the Medicare authorities; and

WHEREAS, At the December 1958 meeting of the American Medical Association house of delegates the Ohio delegation by its efforts effected changes in the A. M. A. trustee sponsored old age program to bring it into agreement with the position of the Ohio State Medical Association;

THEREFORE BE IT RESOLVED, First, That this body commend the Council of the Ohio State Medical Association and the Board of Directors of the Ohio Medical Indemnity for the successful operation of the corporation;

Second, That this assembly take note of the dynamic leadership exercised by the committee on medical care

and the activity of the Ohio delegates to the American Medical Association in the preservation of our principles;

Third, That this house of delegates re-affirm its endorsement of the indemnity approach in meeting our health insurance requirements.

Re: Funds For American Medical Research Foundation

(To be presented by the Montgomery County Medical Society)

WHEREAS, There is widespread misunderstanding of the policy of the American Medical Association regarding the acceptance of funds for the American Medical Research Foundation; and

WHEREAS, There are groups and agencies ready and willing to give funds for health research to the American Medical Research Foundation;

THEREFORE BE IT RESOLVED, That the Ohio State Medical Association Delegates to the American Medical Association present a resolution to the House of Delegates of the American Medical Association, at its next meeting, calling for acceptance of funds by the American Medical Research Foundation offered by any legitimate source.

Re: Ohio Statutes Regulating Practice of Medicine

(To be presented by the Montgomery County Medical Society)

WHEREAS, The Statutes of Ohio regulating the "Practice of Medicine and Surgery, Osteopathic Medicine and Surgery and Limited Branches" in many of its sections employ anachronistic terms such as "capper" and "drummer" (Sec. 4731.22 "A"); and

WHEREAS, Certain provisions of the Statutes are written in a manner that seriously limits or prohibits possibility of enforcement and accurate interpretation such as Section 4731.22 defining "Grossly unprofessional and dishonest conduct" and Section 4731.34 setting forth regulations that "shall be complied with" but provides no penalty for non-compliance;

THEREFORE BE IT RESOLVED, That the Council of the Ohio State Medical Association authorize a thorough study of said statutes by a committee appointed for that purpose and that the committee be requested to make recommendations to revise the statutes in order to modernize and strengthen them so that abuses thereof may be adequately controlled.

Re: Multiple Health Fund Drives

(To be presented by delegate from Marion Academy of Medicine)

WHEREAS, It is felt that the number of medical research fund drives held annually is excessive and burdensome on the general public, and

WHEREAS, It is felt that the United Appeals Drive has shown that multiple drives for similar appeals can efficiently be held as a single drive, and

WHEREAS, It is felt that the multiplicity of organizations for National Health Research problems can well be grouped in one unit, it is

THEREFORE RESOLVED, That the Ohio State Medical Association go on record as recommending to the American Medical Association that the AMA take the leadership in attempting to organize all National Health Agencies under one unit, and it is also

RESOLVED that the AMA sponsor one National

Health Research Drive and then apportion the funds to the various medical agencies on a basis dependent on their relative merits as to their importance from a medical standpoint.

Re: Compulsory Immunization

(To be presented by delegates from Mahoning County)

WHEREAS, It is agreed that immunization of children against diphtheria, whooping cough, tetanus, poliomyelitis and smallpox has greatly reduced the incidence of these diseases and

WHEREAS, By reducing the occurrence rate in those so immunized such immunization has correspondingly diminished the frequency in those not so immunized and

WHEREAS, Such immunization can be accomplished easily and safely in the preschool child, therefore

BE IT RESOLVED, That the Ohio State Medical Association go on record as approving compulsory immunization against diphtheria, tetanus, whooping cough, smallpox and poliomyelitis of all children prior to entrance to either public or private schools, and, further

BE IT RESOLVED, That the Ohio State Medical Association, through its appropriate committee, have introduced and passed into law by the Ohio State Legislature the necessary legislation to effectively implement this resolution.

Re: Medical Research Foundation

(To be presented by the Stark County Medical Society.)

1. WHEREAS, There is an increasing need for basic medical research into all diseases

2. WHEREAS, It is increasingly important that money for such research come from non-government sources

3. WHEREAS, More and more communities in Ohio are raising funds for medical research through Unified Health Drives, United Funds and similar charitable organizations

4. WHEREAS, Leadership by physicians is urgently needed in this field

THEREFORE BE IT RESOLVED, That the Ohio State Medical Association

1) Establish an Ohio State medical research foundation into all diseases

2) That such a research foundation be administered predominately by physicians

3) That this Ohio State medical research foundation be raised by contributions from Unified Health Drives, United Funds or similar charitable organizations and physicians throughout Ohio.

Re: Free Choice of Physicians In Workmen's Compensation Cases

(To be introduced by delegate from Belmont County.)

WHEREAS the Ohio State Medical Association has always stood for reasonable degree of free choice of physician, and

WHEREAS Section 22 of the Ohio Industrial Commission Code precludes such reasonable free choice of physician to injured employees of self-insured employers.

THEREFORE, BE IT RESOLVED, that the Ohio State Medical Association go on record as opposing Section 22 of the Ohio State Industrial Commission and letting this opposition be known to the necessary authorities and that

all reasonable action be taken to secure revocation of said Section 22 of the Ohio State Industrial Commission Code.

Re: Regulation of Speed and Noise of Ambulances

(To be presented by delegate from Lucas County)

Traffic accidents are taking an appalling toll of our citizenry; there were 135 accidents with 8 deaths in Ohio in 1957 involving emergency vehicles.

As physicians we are avowed guardians of the general welfare of our fellow men and

WHEREAS, the excessive speed and noise exhibited by ambulances creates confusion on the city streets and jeopardizes the safety of lives,

WHEREAS, medical experience has shown beyond argument that no useful purpose has been accomplished by noisy ambulances proceeding at excessive speeds,

WHEREAS, medical experience has demonstrated that co-ordinated timing and team work rather than speed determines the outcome in emergency situations,

WHEREAS, studies in metropolitan centers has shown that 98.0 per cent of cases were adequately handled within the 35 m.p.h. restriction,

WHEREAS, ambulance driver personnel trained in the proper handling of accident victims are prepared to render emergency first aid to victims at the scene of an accident, thereby nullifying the need for excessive speed,

WHEREAS, any measures that promote safety in vehicular traffic as outlined by the Ohio Department of Highway Safety should be given consideration;

THEREFORE BE IT RESOLVED, that the Ohio State Medical Association recommend to the Ohio State Legislature

1) That all ambulances, both private and police, be required by edict to obey all traffic laws, in conformity with other vehicular traffic as regards speed, right of way, traffic lights and signs and common courtesies;

2) That a program of education for proper training of all ambulance personnel in the emergency care of accident victims be initiated and maintained; and

3) That such properly trained personnel be licensed through qualified channels by examination, renewable at periodic intervals.

Re: Polio Immunization

(To be presented by delegate from Cuyahoga County)

WHEREAS, a safe effective poliomyelitis vaccine has now been developed, and

WHEREAS, a widespread community polio vaccine program sponsored by the Academy of Medicine of Cleveland and Cuyahoga County Medical Society has proved to be most effective in reducing the number of cases of poliomyelitis,

THEREFORE BE IT RESOLVED: I. That the Ohio State Medical Association urge the state legislature to establish laws requiring the immunization of all public school children against polio.

II. That this polio vaccine program be made a part of the health program of the public and parochial schools of Ohio.

Re: Social Security for Physicians

(To be presented by delegate from Cuyahoga County)

WHEREAS, physicians are the only group at present not included in the Federal Old Age and Survivors In-

surance Program, commonly called "Social Security," and

WHEREAS, non-inclusion of physicians in "Social Security" has been due in large part to official opposition to their inclusion on the part of the American Medical Association and its component Associations and Societies, and

WHEREAS, The October, 1958 poll of the members of the Ohio State Medical Association on the question of participation in "Social Security" indicated that of the members interested enough to have an opinion and vote, 59.9 per cent were in favor of inclusion of physicians in the "Social Security" program.

THEREFORE BE IT RESOLVED, that the House of Delegates of the Ohio State Medical Association record itself as approving in principle the participation of physicians in the Federal Old Age and Survivors Insurance Program, commonly called "Social Security," and

BE IT FURTHER RESOLVED, that this action in approving participation in the Federal Old Age and Survivors Insurance Program be reported to the House of Delegates of the American Medical Association at its June, 1959 meeting.

Re: Bed Taxes on Physicians

(To be presented by delegate from Cuyahoga County)

WHEREAS, the practice of direct assessment by a hospital or its agent of a fee or tax (such as an admission fee, operating room fee, per diem fee, etc.) on a physician for use of hospital facilities by the physician's patient is growing, and

WHEREAS, such practices are developed to provide funds for capital improvement or administration of hospitals because other sources of revenue are diminishing, and

WHEREAS, although physicians have increased responsibilities for hospitals compared to other citizens, their contribution to hospitals should nevertheless be made under conditions similar to those for all voluntary contributions—freely, independently, and in relation to financial means without fear of reprisal, and

WHEREAS, physician acceptance and cooperation in direct assessment plans may involve coercion and implied threats of sanctions and loss of hospital privileges, and

WHEREAS, a basic tenet of philanthropy is free choice of assignee, and

WHEREAS, in most instances, the above mentioned fee or tax is a hidden additional fee for the patient, involving a third party, a practice defined as unethical by the American Medical Association code of ethics, and

WHEREAS, in most instances, physicians have no representation in the disposition and administration of money when collected by the above mentioned plans, and such collections therefore represent taxation without representation and

WHEREAS, the return to the hospital of part of the fee paid by the patient supposedly as reimbursement for service of the physician alone may well be a modified form of fee-splitting as defined by the Judicial Council of the American Medical Association,

THEREFORE BE IT RESOLVED, that the Ohio State Medical Association firmly opposes compulsory assessment of physicians with or without the majority approval of the medical staff of a hospital through such devices as an admission fee, operating room fee, per diem fee, bed tax fee, or other such fees. Contribution to a hospital by a hospital's medical staff for either day to day opera-

tion or construction of new facilities should be on a completely voluntary basis.

Re: Licensing of Paramedical Groups

(To be presented by delegate from
Cuyahoga County)

WHEREAS, numerous paramedical groups now exist that assist physicians in diagnosing and treating patients; and

WHEREAS, there appears to be an ever increasing desire on the part of these paramedical groups to enhance their stature through various means; and

WHEREAS, Senate Bill Number 11 (Ocsek-Renner) has been introduced into the Ohio State Legislature calling for the creation of a State Board of Psychologists for the certification and regulation of psychologists; and

WHEREAS, organized medicine at every level is taking added interest in the affairs of these paramedical groups and is making a conscientious effort to bring prestige to these medical assistants; and

WHEREAS, the House of Delegates of the American Medical Association at the interim session in December, 1958, went on record as encouraging the voluntary registration of paramedical personnel; and

WHEREAS, the House of Delegates at the said December meeting also opposed the extension of governmental licensure and governmental registration;

THEREFORE BE IT RESOLVED, that the Ohio State Medical Association opposes governmental licensure or registration for any paramedical groups; and

BE IT FURTHER RESOLVED, that the Ohio State Medical Association vehemently reiterates its stand that such paramedical groups should function only under the adequate supervision of licensed physicians and surgeons.

Ninth District and GP's of Area

Plan Program for May 7

The Ninth Councilor District of the OSMA has combined forces with the local organization of the American Academy of General Practice to sponsor a postgraduate program on Thursday, May 7. Place of meeting is the Elk's Auditorium in Portsmouth with the Scioto County Medical Society as host in cooperation with Dr. C. L. Pitcher, Ninth District Councilor.

The program with speakers from The Ohio State University College of Medicine has been announced as follows:

12:30 P. M. Registration

1:00 P. M. Thomas E. Schaffer, M. D., Emergencies in The Newborn.

2:00 P. M. Harry E. LeFever, M. D., Interpretation of Neurological Findings.

3:00 P. M. Emmerich von Haam, M. D., Interpretation of Liver Function Tests.

4:00 P. M. George J. Hamwi, M. D., Oral Hypoglycemic Agents.

5:00 P. M. Joseph M. Ryan, M. D., Intractable Heart Failure.

6:30 P. M. Refreshments

7:00 P. M. Dinner

Speaker (non-medical) to be announced.

Do You Know? . . .

Dr. H. M. Platter, Columbus, secretary of the State Medical Board, was honored recently by Selective Service for more than 10 years of service. He is chairman of the Southern District Appeal Board. Colonel Harold L. Hays, state SS director, presented certificates to him and eight other persons.

* * *

Dr. J. E. Tuckerman recently was named chief surgeon emeritus of the Cleveland Euclid-Glenville Hospital after 51 years on the staff. He remains a surgical consultant.

* * *

A \$116,400 March of Dimes grant has been made to the University of Cincinnati and the Children's Hospital Research Foundation by the National Foundation to continue studies by Dr. Albert B. Sabin on live-virus polio vaccine and problems of a number of viruses other than polio.

* * *

Dr. Herbert T. Wagner, of Bronxville, became the new executive director of the Medical Society of the State of New York on December 1, succeeding Dr. W. P. Anderson, who will continue as the Society's elected secretary. Dr. Wagner, formerly was Regional Consultant for the National Foundation.

* * *

Mutual of Omaha as Medicare administrator for Ohio processed 17,228 Medicare bills submitted by Ohio physicians, amounting to \$1,368,704 in 1958 compared to 11,871 bills in 1957, amounting to \$885,931, a gain of 44 per cent in claims and 57 per cent in dollars.

Libel Suit Filed

Adolphus Hohensee, health lecturer and nutritionist, has filed a \$10 million dollar libel and antitrust suit in the Federal District Court in Cleveland, against the Beacon Journal Publishing Co., John S. Knight, its president and editor, and Robert Feldkamp, its reporter; the American Medical Association and its officers; the Summit County Medical Society and its officers; the Akron Better Business Bureau; the Brush-Moore Newspaper, Inc., publishers of the *Canton Repository*, and J. G. Green, the *Canton Repository* editor; W. J. Hine, Canton Safety Director; and many John Doe's. On November 24, 1958, the AMA filed a motion to quash service and to dismiss the complaint, as well as a brief in support thereof. The Court has not made a ruling in this case.

Woman's Auxiliary Annual Meeting

DESHLER-HILTON HOTEL

APRIL 20, 21, 22, 23

Co-Chairmen—Mrs. Homer Anderson, Columbus,
and Mrs. Edward Turner, Columbus

MONDAY, APRIL 20

- 9:00 A. M. Resolutions Committee.
10:30 A. M. Budget Committee Meeting—President's Suite.
Resolutions Committee.
Registration.
1:00 P. M. Board Meeting—Room 307.
3:00 P. M. Opening Day Tea—Victorian Room.
6:00 P. M. Dinner for Board Members—Room 1210-1212.
8:30 P. M. Board Meeting—Room 307.

TUESDAY, APRIL 21

- 8:30 A. M. Registration.
9:00 A. M. Formal Opening—Yellow Room.
Presiding: Mrs. C. H. Bell, Mansfield, President.
Invocation.
Pledge of Allegiance to the Flag.
Pledge of Loyalty—Honorary Member of the State Auxiliary.
Greetings: Dr. J. L. Henry, Grove City, President, Columbus Academy of Medicine.
Address of Welcome: Mrs. George O. Kress, President, Woman's Auxiliary to the Columbus Academy of Medicine.
Response: Mrs. Harry Wain, President, Woman's Auxiliary to the Richland County Medical Society.
Introduction of Convention Chairmen.
Announcements.
Report of Roll Call Chairman.
Adoption of Rules and Program of Convention.
Minutes of 1958 Convention—Mrs. John D. Dickie, Lucas County.
Treasurer's Report—Mrs. A. L. Kefauver, Franklin County.
Report of Board of Directors—Mrs. John D. Dickie, Lucas County.
Report of Nominating Committee—Mrs. V. R. Frederick, Champaign County.

Report of Resolutions Committee—Mrs. George O. Kress, Franklin County.

Report of Revisions Committee—Mrs. Karl F. Ritter, Allen County.

President's Address—Mrs. C. H. Bell, Richland County.

Election Instructions—Mrs. A. Paul Hancuff, Parliamentarian, Lucas County.

Election of 1960 Nominating Committee.

Election of Delegates to the Annual Meeting of the Woman's Auxiliary to the American Medical Association.

Recess.

12:00 Noon Luncheon—Grand Ballroom.
Honoring: National representative; past-presidents and honorary members of the Woman's Auxiliary to the Ohio State Medical Association; out-of-state guests; state board members and county presidents.

Invocation—The Reverend Otis A. Maxfield, First Community Church.

Program—Style show by Montaldo's.

2:30 P. M. Second Business Session—Yellow Room.

In Memoriam—Mrs. William H. Evans, Mahoning County.

3:00 - 4:30 Panels.

6:30 P. M. Gavel Club Dinner.

WEDNESDAY, APRIL 22

- 8:30 A. M. Registration.
9:00 A. M. Third Business Session—Yellow Room.
Presiding: Mrs. C. H. Bell, Mansfield, President.
Report of Roll Call Chairman—Mrs. Ollie Goodloe, Columbus.
Report of Convention Chairman—Mrs. Homer Anderson, Franklin County.
Minutes of Previous Meeting—Mrs. John D. Dickie, Lucas County.

Report of Tellers.

Unfinished Business:

(Continued on Next Page)

Report of Revisions Committee—
Mrs. Karl F. Ritter, Allen
County.

Report of Resolutions Committee
—Mrs. George O. Kress,
Franklin County.

New Business:

Report of the Finance Committee
—Budget—Mrs. V. R. Fred-
erick, Champaign County.

Presentation of the American
Medical Education Foundation
Awards—Mrs. George Cooper-
rider, Franklin County.

Recess.

12:00 Noon Doctor's Day Luncheon — Grand
Ballroom, Deshler Hilton Hotel.

Honoring: George A. Woodhouse,
M. D., President, Ohio State
Medical Association; Frank H.
Mayfield, M. D., President-Elect,
Ohio State Medical Association;
C. L. Pitcher, M. D., H. T. Pease,
M. D., C. A. Gustafson, M. D.,
members of Advisory Committee;
James L. Henry, M. D., Grove
City, President, Columbus Acad-
emy of Medicine; Merrill D.
Prugh, M. D., State Chairman,
A.M.E.F., Ohio State Medical
Association; John S. Hattery,
M. D.; Dr. and Mrs. C. H. Bell;
Dr. and Mrs. C. A. Colombi; and
all Ohio doctors.

Invocation — The Reverend Ray-
mond V. Kearns, Jr., Broad Street
Presbyterian Church.

Program—"Buzz Saws" barber shop
quartet.

2:30 P. M. School of Instruction for all mem-
bers—Yellow Room.

Introductory remarks—Mrs. C. H.
Bell, President.

Presentation of Officers in charge of
Program:

Mrs. C. A. Colombi, President-
Elect.

Mrs. George T. Harding, III,
First Vice-President.

Mrs. Myron W. Thomas, Second
Vice-President.

Mrs. Gaston B. Hannah, Third
Vice-President.

7:30 P. M. Annual Banquet, Ohio State Medi-
cal Association, Grand Ballroom,
Neil House.

THURSDAY, APRIL 23

8:30 A. M. Registration.

9:00 A. M. Fourth Business Session — Yellow
Room.

Presiding—Mrs. C. H. Bell, Presi-
dent.

Report of Roll Call Chairman.

Report of Convention Chairman.

Minutes of Previous Meeting—Mrs.
John D. Dickie, Lucas County.

Presentation of *Today's Health*
Awards—Mrs. Morton E. Block,
Montgomery County.

Presentation of Credits and Awards
—Mrs. S. L. Meltzer, Scioto
County.

Address.

Report of Nominating Committee
—Mrs. V. R. Frederick, Cham-
paign County.

Election of Officers.

Installation of Officers.

Presentation of Gavel and Presi-
dent's Pin—Mrs. C. H. Bell.

Presentation of Past-President's Pin
—Mrs. A. Paul Hancuff, Gavel
Club President.

Inaugural Address—Mrs. C. A.
Colombi.

Adjournment.

1:00 P. M. Post-Convention Board Luncheon
and Meeting—Room 307.

Presiding—Mrs. C. A. Colombi.

Arthritis—Rheumatism Programs At Pitt Medical School

As one feature in the graduate training program in Arthritis and Rheumatism, the Section on Rheumatic Diseases, Department of Medicine, University of Pittsburgh, has organized two special conferences to be held on April 2 and 3, at the auditorium of the Pitt Schools of Health Professors Building. A cordial invitation has been extended to members of the Ohio State Medical Association to attend these meetings for which there will be no admission fees:

Conference on Adrenocortical and Related Anti-Inflammatory Steroids

Thursday, April 2, 1959, 9:00 a. m. - 5:00 p. m.;

Graduate Course in Rheumatic Diseases

Friday, April 3, 1959, 9:00 a. m. - 5:00 p. m.

Complete program details may be obtained from Dr. Gerald P. Rodman, assistant professor of medicine, University of Pittsburgh School of Medicine, who is director of the arthritis and rheumatism graduate training program.

The Ohio State University College of Medicine Was Founded at Willoughby, Ohio, 125 Years Ago

ON THE WEEK-END of April 24-25, the Ohio State University College of Medicine will celebrate its 125th anniversary. On Friday, April 24, alumni of the school will join with other members of the Ohio State Medical Association in the final day's program of the 1959 Annual Meeting of the OSMA in Columbus. Alumni of the school will present an outstanding program as part of the OSMA meeting. On the following day, OSU alumni will hold class reunions and "rounds" at the University Health Center. So that readers of *The Journal* will know something about the founding of the Ohio State University College of Medicine 125 years ago, *The Journal* asked Dr. Jonathan Forman, Emeritus Professor of the History of Medicine in The Ohio State University, to prepare an article on the school's founding. Dr. Forman kindly consented to do so. This is his story.

* * *

ONE OF THE LESSONS which we can learn from history is that Medicine follows the social trend. It is never a leader but it is intimately woven into the social fabric. In these days of social change perhaps we physicians would do well to give more heed to these facts. Perhaps the future would be brighter both for us and for our country if physicians were all to take an active part in defending their country from centralization and stateism and would fight vigorously for private enterprise.

In the early days of this state, almost all of its physicians were apprentice-trained. Life was simple. Medicine was mostly an art. Institutional training in Medicine was hardly worth the effort. It offered a bit of crude chemistry not directly applicable to the work at hand and the details of anatomy. This last was important to him who proposed to amputate an arm or a leg.

In 1823, in distant France the first active principles had been extracted from plants and identified. This was the first of a series of fatal blows to cults in the healing arts which culminated some 125 years later in antibiotics for the treatment of infection.

A Plan—a Dream

In 1819, Daniel Drake had established a medical college in Cincinnati and had surrounded himself with a small but brilliant faculty. By 1834 the Asiatic cholera had come and gone. Most Ohio citizens felt certain that Chagrin (Willoughby), because of its excellent harbor and topography, would become the metropolis of Northern Ohio. But just as the Erie Canal made New York City at the commercial expense of Boston so the Ohio Canal made Cleveland instead of Chagrin (Willoughby).

Chagrin (Willoughby), however, had been settled by an enterprising group of citizens who were intent upon becoming leaders not only in commerce but also in culture and learning.

The citizens of Oberlin had established a co-educational college and an abolition center. Nearby Hudson had built an Academy. To the east about 40 miles the citizens of Austinburg had moved the main building of the Grand River Institute from the banks of the river at Mechanicsburg to the college with 40 yoke of oxen.

To outdo its neighbors, the people of Chagrin (Willoughby) decided to make their Lyceum into a University so on March 4, 1834, the Ohio Legislature granted them a charter for the Willoughby University of Lake Erie.

First—a Medical College

As they proceeded to organize their new institution, it was only natural that they should establish the Medical College first. There were several reasons for this.

First, it was by far the cheapest form of higher education and required only a lecture hall and a preparation room. It could be operated by a part time faculty. Not only local physicians could be so employed but there was also a battery of travelling professors from the east—each with a reputation in his specialty who would gladly come and give his lecture.

In the village of Chagrin (Willoughby) at this time, too, there were two highly respected physicians, Dr. John M. Henderson and Dr. George W. Guard. They had come along from Herkimer, New York, into the village some 14 or 15 years before and had attended the Fairfield Medical School. For one of these Dr. Wetzel Willoughby had served as preceptor. Also this

Dr. Willoughby had substantial land holdings in the area.

Drs. Guard and Henderson, leaders in the project, were, of course, friends and admirers of their old professor, now head of their Alma Mater—The Fairfield Medical School with two hundred students.

The inclusion of Willoughby's name in the charter would afford additional funds from Dr. Willoughby but even more important the inclusion of his name would give prestige to the new school.

It would aid in securing teachers and, more important, students for there were in Ohio and westward several hundred medical practitioners who had been students under Willoughby.

It was the first instance in the United States of a medical school being named after an individual. It happened later when the name was changed to Starling as it did for Rush, Beaumont, and Toland.

In December, 1834, a few months after the school had been organized the name of the town was changed to Willoughby.

The Faculty Grows

The first two years of the existence of this school were not too successful but by the third year the faculty had been strengthened by experienced teachers including Dr. John Delamater, considered to be one of the best teachers of medicine in the nation and Jared Potter Kirtland, eminent not only as a physician and teacher but as a horticulturist and scientist of international reputation. In his time he taught at Cincinnati, Willoughby and Western Reserve. He founded *The Ohio Farmer* and had much to do with the establishment of the Ohio State University and the direction which agricultural education took in this country when the land grant colleges were set up.

In the sessions of 1841-42 dissensions arose in the faculty and also there was public clamor against the school over the subject of securing anatomical material.

The next year the controversies increased. Four of its faculty resigned, intent upon starting a new school in Cleveland since they could not move Willoughby there.

It was evident that Cleveland was going to be a big city and the future of Willoughby was uncertain. The president and several of the trustees resigned in sympathy or for other reasons of their own.

A Rival Is Born

Those who were left, in retaliation, blocked the dissenters from getting a charter for the new

Cleveland School. So the four professors applied to the Western Reserve College for affiliation which had sometime before announced its intention of founding a medical college.

In November, 1843, the Cleveland Medical College opened its doors. The trustees at Willoughby reorganized and strengthened their faculty with men who were also on the faculty at the Berkshire Medical Institute at Pittsfield, Massachusetts.

The rivalry for students between the school in Cleveland and the one at Willoughby was intense, involving the publication in newspapers of polemical articles from both groups but especially from the Willoughby one. It gradually became apparent that at that time there was not room for two schools existing some 20 miles apart. Willoughby, being a small town, there was more prejudice against dissection than in the growing metropolis of Cleveland. The last commencement at Willoughby was held January 26, 1847.

Move to Columbus

Dr. John Butterfield, the Dean of Willoughby University of Lake Erie, in these latter days deserves more at the hands of our historians than he has ever had. He was a great man, a scholar, and an excellent medical journalist.

Dr. Butterfield, along with the others left on the faculty of Willoughby, finally became convinced that the rural medical college could not survive and that, therefore, their Medical College should be moved to a city. Butterfield, himself, was strongly in favor of moving to Columbus.

This with the assistance of Dr. Richard L. Howard, Columbus' first surgeon, they were able to do. The Willoughby Medical College of Columbus opened its doors at its first session on August 18, 1847.

The first few years the College used temporary quarters. The trustees purchased half of the Clay Club House, standing on the present site of the Grand Theatre, and moved it to West Gay Street near High.

This wooden structure was remodelled into an amphitheatre seating 150 persons with three small rooms—one for anatomical purposes and two for the storage of chemical apparatus, charts, mannequins and skeletons. Later, additional lecture rooms were rented in the new Wesley Chapel which stood nearby on High Street on the present site of the "Wesley Block."

Lyne Starling

It has been said that Lyne Starling was interested in getting this school from the beginning. William Starling Sullivan, a nephew of Lyne Starling, became a member of the first Board of

Trustees and on December 18, 1847, Starling made a gift of \$30,000.00 on condition that a hospital for the treatment of the sick poor should be erected in connection with the College. He also stipulated that a place on the faculty should be made for Dr. Francis Carter, whose wife was his niece, Ann Starling.

This was most agreeable to all for Dr. Carter had done much to interest the benefactor and was held in high regard by the whole community. Incidentally, his residence was only recently torn down to make the parking lot on East State Street just west of Schoedingers and across the street from Zells.

The world famous cancer specialist and active alumnus of Ohio State University, the late Francis Carter Wood of Columbia University was his grandson as was the well-known Columbus internist, the late John Dudley Dunham who was raised by his parents just back of his grandfather's house on Town Street in the residence now being used as the Columbus-Celina Bus Station.

The name of the school was changed to The Starling Medical College. Mr. Starling had not asked for this but was naturally greatly pleased.

A lot on the frog pond on East State Street was purchased. Plans were submitted by many architects. That of R. A. Sheldon of New York won. The estimated cost was \$35,000.00—more than was in the building fund—leaving nothing for equipment of either school or the hospital.

The plan was so attractive and appealing to everyone that it was decided to go ahead and build what, until this last year when it was torn down, was generally considered the outstanding piece of architecture in the city and one of the finest in this country.

A New Approach

Such was the beginning of The Starling Medical College and the St. Francis Hospital whose foundation was laid in March, 1849. Unfortunately, as is usually the case, the architect had greatly underestimated the cost.

Therefore, the institution which began with a larger endowment than any other medical college and which had set a new example in medical education for the first time a medical college and teaching hospital were to be under the same Board of Trustees was in its fourth year handicapped by debt.

Until 1875 the larger portion of its income was absorbed by debt, leaving little for the pay of ordinary expenses, salaries for teachers, or the completion of the building beyond the necessary repairs and finish the Museum.

Because of the consequent lack of funds, the

College adopted the principle of a resident faculty "in order that the teachers might devote a part of their time throughout the whole year to the development of the school." Meanwhile, the teachers, with the exception of the lay professor of chemistry worked without one cent of pay.

In 1875, Columbus Medical College was organized and in 1892 it was merged into Starling Medical College. The same year, Ohio Medical College was organized with its facilities in Columbus. Starling and Ohio Medical were consolidated in 1907 as Starling-Ohio Medical College. In 1914, the College of Medicine at Ohio State University was established and at that time Starling-Ohio gave to the State of Ohio all of its properties, both real and personal, for this purpose. Thus the Ohio State University school ranks as the second oldest medical college in the state, standing upon the foundation of six medical schools which have been referred to.

Such was the beginning of medical education in northern and central Ohio which descended in a direct line to our present medical schools. One hundred twenty-five years contribution to the Medical Profession.

—Jonathan Forman, M. D.

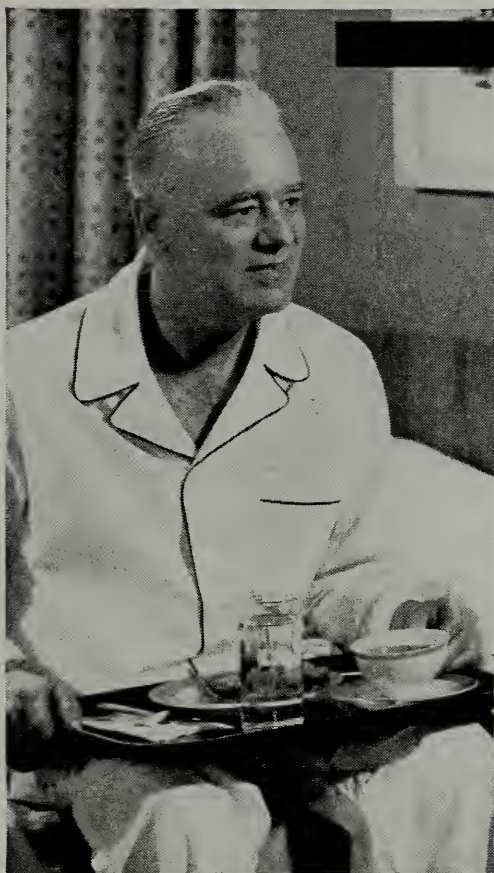
Ohio Doctors Alerted for Unusual Outbreaks of Influenza

With widespread outbreaks of influenza in England and other European countries, the U. S. Public Health Service has put out an alert for unusual incidence of influenza in this country.

Ohio physicians have been requested to cooperate with local and state health workers by passing on to health authorities a report of any outbreaks in this state.

Dr. Ralph E. Dwork, director of the Ohio Department of Health, has issued a communication to local health commissioners requesting that they advise the Communicable Disease Division of the Department of any undue absenteeism in schools or industries. Dr. Dwork further requested that throat washings and blood specimens be taken and forwarded on the first few cases reported in any area.

As of mid-February, Dr. Dwork reported no indication of an unusual incidence of influenza in Ohio and no need for mass immunization. If and when the situation indicates, recommendations will be issued. "For those individuals who wish to be vaccinated or for industrial groups wishing to carry out mass immunization, it would seem reasonable to recommend vaccine containing strains of both A and B virus," he reported.



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A multitude of case histories are now adding individual clinical color to the earlier controlled investigations which defined the actions of Nilevar as an effective aid in reversing negative nitrogen balance and in building protein tissue.

In typical case reports such gratifying comments as these appear:

Underweight — "Appetite considerably increased within one week. Sense of well-being and vigor increased along with increased appetite."

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The dosage for adults is 20 to 30 mg. daily in single courses no longer than three months. For children the daily dosage is 0.5 mg. per kilogram of body weight, in single courses no longer than three months.

Nilevar is supplied in tablets of 10 mg., ampuls of 25 mg. (1 cc.) and Nilevar Drops of 0.25 mg. per drop.

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SEARLE

In Memoriam . . .

William Lewis Counts, M.D., Chillicothe; Medical College of Ohio, Cincinnati, 1897; aged 92; died January 12; member of the Ohio State Medical Association and recipient of the OSMA 50-Year Award; member of the American Medical Association. Dr. Counts devoted his entire professional career to practice in the Ross County area, first making his residence in Yellow Bud and moving to Chillicothe in 1903. Only last year he gave up practice completely. Active in community affairs, he was a member of the Methodist Church. Dr. Richard L. Counts, also of Chillicothe, is one of two sons who survive. Other survivors include a daughter, a sister and two brothers.

Robert Bruce Curl, M.D., Toledo; Eclectic Medical College, Cincinnati, 1916; aged 81; died January 21; former member of the Ohio State Medical Association and the American Medical Association. Dr. Curl was a practicing physician for 43 years. In recent years he was physician for the Toledo Public Schools and staff doctor for the Toledo Health Department. A veteran of World War I, he was a past-commander of the V. F. W. post. He also was a past-president of the Exchange Club. Survivors include his widow, a stepson and a sister.

Daniel J. Davies, M.D., Cincinnati; Miami Medical College, Cincinnati, 1900; aged 87; died January 27; member of the Ohio State Medical Association and recipient of the OSMA 50-Year Award; member of the American Medical Association; diplomate of the American Board of Obstetrics & Gynecology. A practicing physician over a period of 55 years before his retirement four years ago, Dr. Davies served most of his professional career in Cincinnati. He was a member of the Presbyterian Church, the Masonic Lodge and the Rotary Club. Surviving are his widow, a daughter, two sisters and a brother.

David D. Delzell, M.D., Toledo; University of Illinois College of Medicine, 1912; aged 73; died December 22; member of the Ohio State Medical Association and the American Medical Association. Dr. Delzell practiced medicine for 46 years in Toledo. He was a member of several Masonic bodies. Survivors include his widow, a son and a daughter.

Thomas W. Geoghegan, M.D., St. Paul, Minn.; University of Buffalo School of Medicine, 1925; aged 57; died January 10; former member of the Ohio State Medical Association. Dr. Geoghegan was medical director of the St. Paul Red Cross

blood program. He held a similar position in Cleveland before leaving Ohio and prior to that practiced for many years in Fostoria. During World War II he served with the Navy and held the rank of commander. Surviving are his widow, a daughter and two sons, one of whom is Dr. Thomas G. Geoghegan, of Cleveland.

Edmund A. Gomolski, M.D., Toledo; University of Michigan Medical School, 1930; aged 55; died January 26; member of the Ohio State Medical Association and the American Medical Association. Dr. Gomolski practiced medicine for 13 years in Minster before moving to Covington in 1945. He retired for reasons of health and returned to his native Toledo only recently. Surviving are his widow, a daughter, a son, four sisters and four brothers.

Otto M. Hendershot, M.D., Columbus; Baltimore Medical College, 1902; aged 90; died January 14; former member of the Ohio State Medical Association. Dr. Hendershot practiced in East Liverpool until 1930 and in other Ohio communities before moving to Columbus. He is survived by his widow, two sons and a daughter.

Robert D. Hostetter, Sr., Dayton; Jefferson Medical College of Philadelphia, 1916; aged 64; died January 12; member of the Ohio State Medical Association, the American Medical Association and the American Academy of Pediatrics. Dr. Hostetter practiced his profession for more than 30 years in Dayton before his retirement in 1952. He was active in numerous local organizations, among them the Rotary Club, the Presbyterian Church and several Masonic bodies. During World War I he served as medical officer with the Navy. Surviving are his widow, three daughters, a son, a sister and two brothers.

Clarence L. Hutchins, M.D., Delta; Toledo Medical College, 1908; aged 73; died January 11; member of the Ohio State Medical Association and recipient of the OSMA 50-Year Award; member of the American Medical Association; Fellow of the American College of Surgeons. Dr. Hutchins practiced medicine continuously in the Delta area beginning in 1909, and formerly was Fulton County health commissioner. Surviving are his widow, a son and a brother.

Aaron J. Kanter, M.D., Cincinnati; University of Cincinnati College of Medicine, 1934; aged 49; died January 12; member of the Ohio State Medical Association, the American Medical Association.

ciation and the American College of Chest Physicians. Dr. Kanter formerly conducted a private practice in Cincinnati and for the past 12 years he was associated with the Veterans Administration. A member of the Wise Temple and the American Trudeau Society, he is survived by his widow, two daughters, a son and his mother.

Arthur J. McCracken, M.D., Bellefontaine; Medical College of Indiana, 1901; aged 85; died February 1; member of the Ohio State Medical Association and the American Medical Association. Dr. McCracken had been practicing physician in Bellefontaine since 1906. For 32 years he was local health commissioner and for 12 years was Logan County coroner. A veteran of World War I, he was active in many programs of the American Legion. Other affiliations included memberships in the Presbyterian Church, the Masonic Lodge and the Kiwanis Club. Surviving are his widow, a daughter, two sons, a brother and two sisters.

William Millberg, M.D., Ashtabula; Jefferson Medical College of Philadelphia, 1925; aged 61; died February 1; member of the Ohio State Medical Association, the American Medical Association, the International College of Surgeons and the American Academy of General Practice. A life resident of Ashtabula, Dr. Millberg served all of his professional career there. He, in addition to his professional affiliations, was active in the Masonic Lodge and the Elks Lodge. Surviving are his widow, a daughter and two sons, Dr. Richard S. Millberg, also of Ashtabula, and Dr. William B. Millberg, of Philadelphia; also a sister.

Almer D. Ritenour, M.D., Jamestown; University of Cincinnati College of Medicine, 1922; aged 69; died January 24; member of the Ohio State Medical Association and the American Medical Association. A native and life resident of the vicinity, Dr. Ritenour practiced for 36 years in Jamestown. Former president of the Greene County Board of Health, he was active in a number of community affairs and organizations; was a member of the Methodist Church, several Masonic bodies, the Lions Club and local Businessmen's Clubs. Surviving are his widow, two daughters and a sister.

Ira B. Scott, M.D., Cleveland; University of Tennessee College of Medicine, 1923; aged 70; died February 4; former member of the Ohio State Medical Association. Dr. Scott practiced for some 30 years in Cleveland. He was active for many years in the Methodist Church. Surviving are his widow, a daughter and two sisters.

Dyle J. Slosser, M.D., Defiance; Ohio State University College of Medicine, 1913; aged 75; died January 15; member of the Ohio State Medical Association and the American Medical Association. A practicing physician for a period of 45 years, Dr. Slosser had a distinguished career also in medical organization work. He held the office of president and vice-president in the Defiance County Medical Society for a number of terms and was secretary of that organization for more than 16 years. He also represented the local society in the OSMA House of Delegates for many terms and served on a number of local committees including the Legislative Committee. For the term 1929-1931 he served on The Council of the OSMA, as Councilor of the Fourth District. Dr. Slosser was Defiance County coroner for several years and was a past-president of the Ohio State Coroners' Association. He opened his practice in Ridgeville Corners in 1913, served with the Army Medical Corps during World War I and started his practice in Defiance in 1919. He was a 32nd Degree Mason and member of the board of the local Methodist Church. Surviving are his widow, three daughters, a son, Dr. Paul J. Slosser, Yuma, Arizona; also a brother.

David B. Steuer, M.D., Cleveland; Western Reserve University School of Medicine, 1895; aged 93; died January 30; former member of the Ohio State Medical Association. A practicing physician for many years in Cleveland and former member of City Council, Dr. Steuer pioneered in a number of local sanitary measures. He was one of the organizers of Mt. Sinai Hospital and Children's Hospital in Cleveland and was active in a number of local organizations such as the Knights of Pythias, the Masonic Lodge, Chamber of Commerce and the Hungarian Benevolent and Social Union. Surviving are two sons, a daughter, two brothers and a sister.

Anna B. Watson, M.D., Cadiz; Woman's Medical College of Pennsylvania, 1894; aged 91; died December 12; member of the Ohio State Medical Association and the American Medical Association. A resident of Cadiz for a number of years, Dr. Watson was a former medical missionary in Egypt. Nieces and nephews survive.

Howard H. Webster, M.D., Dayton; Hahnemann Medical College and Hospital of Philadelphia, 1903; aged 78; died January 24; former member of the Ohio State Medical Association and recipient of the OSMA 50-Year Award. Dr. Webster practiced his profession in Dayton for 54 years. He is survived by his widow, a daughter, a son and a sister.

Poison Information Centers in Ohio

These centers have agreed to cooperate in a program to extend their services to any physician requesting information from them. When a center is called the physician should have four basic facts in mind: (1) The full name or brand of the product ingested or inhaled; (2) An accurate estimation of the amount of the particular agent ingested; (3) The time of ingestion; (4) The age and weight of the patient.

Location	Facility	Telephone
Akron	Children's Hospital W. Bowery and W. Bechtel	BL 3-5531, Ext. 246
Cincinnati	The Academy of Medicine of Cincinnati 152 E. Fourth St.	PA 1-2345
Columbus	Children's Hospital 561 S. 17th St.	CL 8-9783
Cleveland	Cleveland Academy of Medicine 2121 Adelbert Road	CE 1-4455
Springfield	City Hospital E. High St. and Burnett Rd.	FA 3-5531, Ext. 226
Toledo	Toledo Health Department 635 N. Erie St.	CH 4-1961—(Day) GR 9-2244—(Night)

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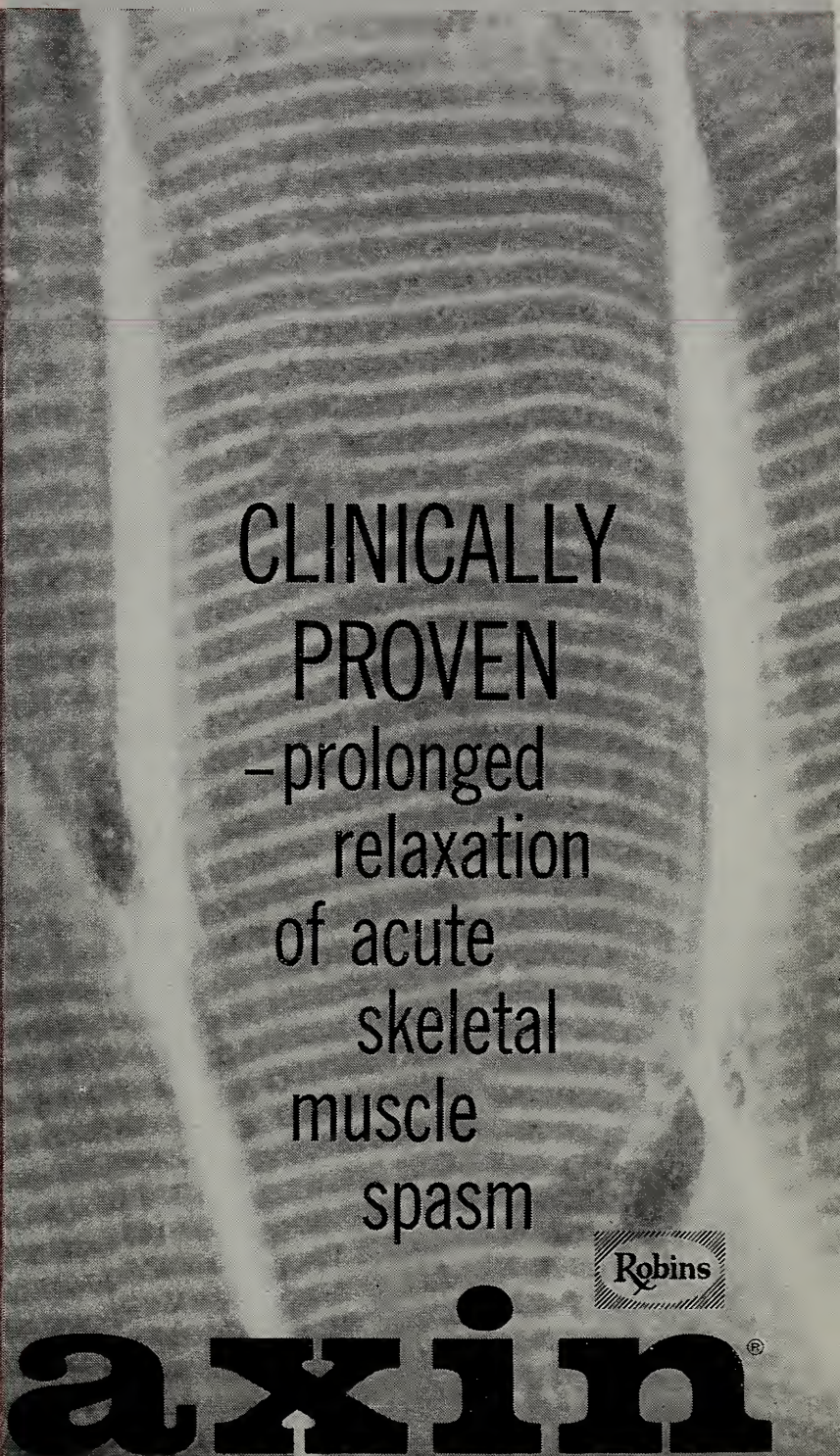
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TABLETS

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SKELETAL MUSCLE SPASM CASES**

	NO. PATIENTS		RESPONSE		
		"marked"	moderate	slight	none
Carpenter ¹	33	26	6	1	—
Forsyth ²	58	"pronounced" 37	20	—	1
Lewis ³	38	"good" 25	6	—	7
O'Doherty & Shields ⁴	17	"excellent" 14	2	1	0
Park ⁵	30	"significant" 27	—	2	1
Plumb ⁶	60	"gratifying" 55	—	—	5
TOTALS	236	184 (78.0%)	34 (14.4%)	4	14

- Highly potent — and long acting.^{1,2,3}
- Relatively free of adverse side effects.^{1,2,3,5,6}
- In ordinary dosage, does not reduce muscle strength or reflex activity.¹

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Voluntary Health Insurance Plans Show Continued Growth

Health insurance in the United States expanded on many levels in 1958 to continue the steady growth it has maintained for the last 20 years, the Health Insurance Institute has reported.

A new record was reached when an estimated \$4.8 billion in health care benefits were paid by all insuring organizations during 1958 to help the public meet the cost of accident and sickness. This surpassed the 1957 benefit payment figure of \$4.2 billion by more than 14 per cent.

At the same time, the number of Americans protected against the cost of hospital and doctor bills through insurance company programs, Blue Cross - Blue Shield and other health care plans, was estimated at 121 million at the end of 1958. Some 70 per cent of the nation's population now have health insurance.

The number of persons covered for major medical expenses climbed from 13.3 million to 16.5 million, an increase of nearly 25 per cent.

A 1958 study by the U. S. Dept. of Health, Education and Welfare revealed progress in providing persons 65 years of age and older with health insurance. The study showed that the number of older age persons with health insurance was growing at a much faster rate than the senior citizen population itself. The government report disclosed that the number of Americans 65 and over increased by 13 per cent from March 1952 to September 1956, while the number of senior citizens covered by health insurance went up 56 per cent. The Institute estimated that 40 per cent of the persons in this age category now have health insurance.

A Health Insurance Institute consumer survey revealed that two out of every five American families with health insurance have used their insurance in the past year to help defray medical expenses.

Clinical Pathology To Be Subject At Bunts Institute Course

The Frank E. Bunts Educational Institute, affiliated with The Cleveland Clinic Foundation in conjunction with the Cleveland Society of Pathologists, is offering a postgraduate course on Clinical Pathology April 2 and 3.

The course will be held on the fourth floor of the North Clinic Building located at Euclid Avenue and East 93rd Street.

Details may be obtained by writing: Education Secretary, Frank E. Bunts Educational Institute, 2020 East 93rd Street, Cleveland 6, Ohio.



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Arthritis Treatment Centers Are Planned by Foundation

A new nationwide network of treatment and evaluation centers for aiding America's millions of arthritis and rheumatism sufferers will be supported with March of Dimes funds raised in the current campaign, Basil O'Connor, president of The National Foundation, has announced. The March of Dimes appeal this year is for \$65,000,000.

According to Dr. William S. Clark, the organization's director, at these centers, evaluation, treatment and rehabilitation of arthritis patients will be combined with clinical research and with programs for teaching modern techniques of arthritis care to doctors and other medical personnel. Dr. Clark said that "research at the centers will include basic studies of the causes of arthritis and investigations seeking new and improved methods of treatment for the long-term problems involved in chronic arthritis."

Dr. Clark said that the foundation "will help pay for needed facilities and equipment and will help staff the centers with doctors, psychologists, nurses, physical therapists, occupational therapists, medical social workers and other specialists essential to the total care and rehabilitation of arthritis patients."

Services at the arthritis centers will be available to physicians, Dr. Clark stated. He said when physicians send patients to their nearest centers for evaluation and treatment, children under 19 with rheumatoid arthritis who need financial assistance will receive it from their National Foundation county chapters. Adults who are helped at the centers will not receive this financial assistance but will benefit from services paid for by the foundation.

The new arthritis centers will offer out-patient treatment primarily. However, the centers will be associated with hospitals where beds will be available for in-patient treatment when necessary.

New Members of OSMA

The following are the names of the new members of the Ohio State Medical Association since January 1, 1959. The list shows the county in which they are affiliated, city in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

Athens County

Kolbein K. Waering,
Nelsonville

Belmont County

Joseph Major,
St. Clairsville
German Ortiz,
Powhatan Point

Clermont County

Phillips F. Greene,
New Richmond

Coshocton County

Milton A. Boyd,
Coshocton

Cuyahoga County

Earl Brightman,
Cleveland
Douglas W. MacDonald,
Cleveland
Walter H. Maloney,
Cleveland
Rolf F. Miller, Cleveland

Fayette County

Ralph Gebhart,
Washington C. H.
Robert A. Heiny,
Washington C. H.

Franklin County

Roy E. Manning, Columbus

Hamilton County

Danute G. Bieliauskas,
Cincinnati
Laimdota Dombrovskis,
Cincinnati
Donald C. Fischer,
Cincinnati
James P. Stewart,
Cincinnati

Henry County

Thomas F. Moriarty,
Napoleon

Huron County

John Blackwood, Jr.,
Norwalk

Licking County

Coloman Perjessy, Hebron

Mahoning County

Ernest E. Alvin, Jr.,
Youngstown
Ching-Chi Chen,
Youngstown
Harry W. Haverland,
Youngstown
Andreas Lutz, Youngstown
Winifred L. Mutschmann,
Youngstown
Marie L. Porter,
Youngstown
Joseph W. Tandatnick,
Youngstown

Mercer County

Ralph D. Bradrich, Rockford

Paulding County

Vladimirus Bazali, Antwerp

Perry County

Alexander P. Demidov,
Corning

Scioto County

Julius V. Molnar,
Portsmouth

Shelby County

Robert I. Curry, Botkins

Stark County

Hammond P. Chen, Canton
Jaroslav Muzyczka, Canton

Summit County

Zouhair Yassine, Akron

Trumbull County

Michael Galose, Girard
Donovan F. Hinchman,
Warren

Wood County

William J. Hockett, Jr.,
Bowling Green
Louis W. Nowack,
Bowling Green



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Medical Survey of Labor Union Families Contemplated

The following details on a medical-hospital survey of families of labor unions now being conducted were published in a recent issue of the *Washington Report on the Medical Sciences*.

The principals are Into. Assn. of Machinists, U. S. Industries, Inc., Columbia University and National Opinion Research Center. The objective: To find out how nearly 90 million Americans are faring under medical and hospital insurance programs supported wholly or in part by industry.

Financing this three-year study is Foundation on Employee Health, Medical Care and Welfare, Inc., a joint undertaking of machinists union and U. S. Industries, Inc., which was established three years ago. Supervisor of the project is Dr. Ray E. Trussel, chairman of Columbia's School of Public Health and Administrative Medicine. Interviewing and other field work will be done by NORC (University of Chicago).

A 3,000-family sampling is contemplated. There will be 750 families in each of these types of coverage: Blue Cross-Blue Shield; indemnity type, as provided for non-operating railway workers; comprehensive medical expense, as provided for General Electric Co. workers, and the direct service type as represented by Kaiser Foundation on the West Coast.

The survey prospectus says answers will be sought to these questions: Which is more important, protection against the catastrophic illness which is comparatively rare or the less expensive, but more common, ailment? Do covered families seek medical care which they might let go by default if they were not protected? Is coverage resulting in an actual saving of money to the employee? Is there a danger of excessive utilization if co-insurance or some other check is not provided?

Also, what relationship exists between frequency of hospitalization and the type of health insurance possessed? Can a feasible system be evolved to make medicines, eye glasses and home-and-office visits includible? To what extent do periodic health examinations and emphasis on preventive care cut down expenses for treatment? Should free choice of practitioner (including chiropractors) be given?

Dr. Trussell told WRMS the household interviews will be divided as follows: In New Jersey, 750 families belonging to Blue Cross-Blue Shield and 250 covered by the railway program, administered by Travelers Insurance Co.; upper New York State, Cincinnati and Milwaukee, with total of 1,000 families, three-fourths in the General

Vital Topics Are Scheduled for Cleveland Medicolegal Meeting

Among subjects to be discussed at the AMA-sponsored medicolegal symposium April 3-4, Hotel Cleveland, will be: Medical and Legal Problems Involved in Narcotic Addiction; Traumatic Neurosis; the Approach of Medicine and the Law to Contingent Fees; Res Ipsa Loquitur in Professional Liability Cases; Impartial Medical Testimony; and the Classic Method of Cross Examining an Expert Medical Witness.

The meeting is open to Ohio physicians and attorneys.

Several outstanding speakers have already agreed to participate. Included are Rufus King, Washington, D. C.; R. Crawford Morris, Cleveland; Truman Rucker, Tulsa; Father Robert F. Drinan, Dean, Boston College Law School; Irving Goldstein, Chicago; and Dr. Robert H. Felix, Bethesda.

At each of the meetings the sessions will be presented for half a day on Friday and a full day on Saturday. Luncheon will be served on Saturday, with no planned program for Friday night. The registration fee for each conference will be \$5.00, to cover the cost of the luncheon and a copy of the proceedings. Advance registrations should be mailed to the Law Division, American Medical Association, 535 North Dearborn Street, Chicago 10.

Electric package (carried by Metropolitan Life) and remainder in the railway plan; San Francisco Bay area, 750 families affiliated with the Kaiser-Permanente program and 250 in the railway health insurance plan.

Cleveland Health Museum Opens Its "New Look at Life" Exhibits

Recently the Cleveland Health Museum, 8911 Euclid Avenue, Cleveland, opened a series of exhibits, "A New Look at Life" as part of its \$100,000 development program. The Flame of Life exhibit explains how the body uses raw materials to produce energy. Other exhibits show how man's various cells and tissues convert energy into useful body functions. The Endless Chain of Life illustrates the stages of man's life.

The exhibit room is to be the Dr. Lester Taylor Memorial Room, dedicated to the Health Museum's first president and benefactor. The museum is open to the public daily 9 a. m. to 5 p. m.; Sundays 1 to 6 p. m. and Wednesday evenings, 7 to 10 p. m.

Tax Decisions of Interest To Physicians

Here are some tax decisions of interest to physicians, summarized by the Law Department of the American Medical Association:

Travel Expenses—A physician and his wife operated a sanitarium for the treatment of alcoholism. In 1953 they took a trip to Europe. During the trip, the physician contacted persons in the medical field and visited hospitals and mental institutions. In their 1953 income tax return, they claimed a deduction of \$7,881 in travel expenses. The Commissioner of Internal Revenue disallowed the entire amount. The Tax Court held that the trip was primarily a pleasure trip finding that 56 days of the 85 day trip were spent in travel covering most of the prominent sight-seeing places of Great Britain and the Continent. Furthermore, the Court said that the physician did not make any preliminary arrangements for visits to hospitals and the like, nor did his records show how much time was spent at each place or what he did on the visits. The Court said, however, that the physician made some effort to look into the problems of his specialty and thus allowed him \$200 for business expenses, but refused to allow any of his wife's expenses. The Tax Court also allowed the physician a deduction of \$575 representing the total cost of 21 separate mailings of postcards to 700 referring doctors, patients and other business contacts which the physician made while on his trip. The Court said that these mailings were clearly an ordinary and necessary business expense. *Ralph E. Duncan and Anne M. Duncan v. Commissioner*; Docket 64901, May 28, 1958, 30 T. C.—, No. 36, Opinion by Judge Mulroney.

Charitable Corporation—Three doctors organized a clinic as a non-profit, non-stock corporation. Its articles of incorporation did not restrict

it to carrying on its operations for charitable purposes and its earnings benefited individual doctors. The clinic's employment agreements with doctors, who rendered medical services, provided that each doctor would bear some of his expenses and would assign his fees to the clinic. The doctors were paid salaries based upon the ratio of each one's charges (fixed by himself) to total charges, the ratio of each one's visits with patients to total visits, and the ratio of new patients treated by each doctor to all new patients. Also, two of the founding doctors, as trustees and members, were in a favored position as to the clinic's retirement pension plan. The Tax Court held that the clinic was not a charitable corporation and hence was not exempt from taxation. *Lorain Avenue Clinic v. Commissioner*, Docket 55754, October 23, 1958, 31 T. C.—, No. 19, Opinion by Judge Harron.

Medical Expenses—The Internal Revenue Service has ruled that the entire cost of maintaining a mentally ill child, while living at a specially equipped children's center where she receives continued medical care from qualified medical personnel, is deductible as a medical expense subject to the limitation prescribed in Section 213 of the Code. The Internal Revenue Service also has held that if, on the basis of competent medical advice, it is deemed necessary for parents to visit their child at regular intervals as a part of her therapy and medical management, the cost of transportation for such visits will qualify as cost of "transportation primarily for and essential to medical care" within the meaning of Section 213 (e) of the Code and will be deductible as a medical expense for Federal income tax purposes. *Rev. Rul. 58-533*.

Dr. Charles Tupper who studied stomach x-rays of 186 Michigan U. students found 41 had stomach ulcers—all discovered for the first time.



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PFIZER LABORATORIES, Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y.

Information, Please, Re: Workers Exposed to Radium Years Ago

The Ohio Department of Health is taking part in a medical-detective type of search for approximately 1,000 "most wanted" individuals.

This search, nationwide in scope, seeks to locate persons who 35 to 40 years ago were employees of industrial concerns which used radium in their work.

They may be persons who painted radium figures on the dials of watches, instruments; persons who prepared the radium paint or experimented with it; even office workers or office managers of plants or laboratories engaged in this work a third of a century ago.

These persons make up the largest group in the United States, possibly in the world, who have been living, in some instances, for at least a generation since exposure to radium, and who in some instances have children or grandchildren.

Interviewing these people and their families, making physical checks when necessary, can lead research workers to knowledge about radiation exposure which is vital to today's atomic age.

Also being sought are any persons who a quarter of a century or longer ago may have taken radium by mouth or injection as part of medical therapy or self-treatment.

Dr. Thomas Mancuso, chief of the Industrial Hygiene Division of the Ohio Department of Health, urges that such persons, or their friends or relatives, contact his division. All information obtained will be considered privileged communication.

Health workers would even like to talk to the families of such workers who may have died in the meantime, Dr. Ralph E. Dwork, Director of the Ohio Department of Health, said. Certain valuable information could be obtained by interviews with family members or even friends, he explained.

Association of American Physicians And Surgeons To Hold Meeting

The Association of American Physicians and Surgeons, an organization dedicated furthering the medical profession's interests in matters of medical economics, public relations, legislation and the free practice of medicine, will hold its 16th Annual Meeting in Fort Worth, Texas, April 2-4. Ohio physicians on the AAPS board of directors are Dr. Charles W. Pavey, Columbus, and Dr. Edward C. Jenkins, Delaware. All physicians who are members of their local medical societies are welcome to attend.



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Pharmaceuticals and the Nation's Health...

Since the Introduction of the Sulfonamides, One Drug After Another Has Become an Ally to the Healing Arts To Relieve Suffering and Save Lives

DURING the period from 1937 through 1955, the death rate in the United States declined 18 per cent. If the rate for 1937—11.3 deaths per thousand of population—had remained constant through 1955, an additional 3,228,734 people would have died. The death rate has not remained constant, however, and over 3 million unidentified people owe their lives to improved care made possible by a chemical revolution in medicine.

A graphic description of the effect of today's drugs on the course of infectious disease can be seen in the rapid drop in the death rate from pneumonia following the introduction and widespread use of sulfonamides and antibiotics.

In 1900 pneumonia, with influenza, was the leading cause of death in the United States. At that time treatment for pneumonia consisted of whiskey and drugs to depress the temperature. The patient and doctor waited for the crisis, at which time neither knew which way the disease was going to go.

In the late 1920's, various anti-pneumonia serums were introduced; as a result, mortality from pneumonia and influenza began to decline during the 1930's. The decline accelerated when the sulfonamides were introduced at the end of the decade, and when penicillin came into widespread civilian use following World War II. In recent years the use of broad-spectrum antibiotics has caused further drops in the combined pneumonia-influenza death rate.

The cost of illness for a pneumonia patient has dropped drastically at the same time. Instead of five weeks of hospitalization and a period of convalescence with doctor, hospital and nursing bills, plus loss of earnings totaling perhaps \$1,000, as was the case in the late 1920's, most cases of lobar pneumonia today are cleared up in less than two weeks with the use of antibiotics—often at home instead of the hospital.

Tuberculosis

As a result of improved case-finding techniques and specific means of treatment, more people are being treated for tuberculosis today than ever before. At the same time the death rate has declined dramatically and the need for hospital beds for tuberculosis patients has dropped.

EDITORIAL NOTE:

During the past twenty years new drugs have been introduced to medicine at an unprecedented rate. These new therapies in the hands of practicing physicians have contributed to the conquest of some of man's age-old disease enemies.

This article attempts to highlight the strides made in the drug industry particularly in the last two decades. It is excerpted from a pamphlet entitled *Facts About Pharmacy and Pharmaceuticals*, published by the Health News Institute.

In a series of articles, *The Ohio State Medical Journal* is endeavoring to set forth the answers to some of the provocative questions being asked about the pharmacy industry, the costs of drugs, drug research, etc. This is the third in the series. The first appeared in the January issue and the second in the February issue.

The decline in tuberculosis mortality in the United States, which began in 1910, has been sharply accelerated during the past 10 years. Tuberculosis deaths dropped from 40 per 100,000 in 1945 to about 10 in 1955. Although this drop may be due in part to a slight decrease in new cases and perhaps in some measure to earlier detection of the disease, it must be primarily a result of improved treatment. Without question, the greatest single factor in the improvement of treatment has been the development of anti-microbial agents active against the tubercle bacillus.

Successful treatment for tuberculosis with streptomycin, dihydrostreptomycin and isoniazid has made better outpatient treatment possible, instead of requiring long term hospitalization for many patients. For example, in 1953 there was a long waiting list for beds at the City of Chicago Municipal Sanitarium. Then a program was adopted whereby patients were discharged from the hospital under certain conditions before their diseases had reached the status of inactivity. Treatment with drugs was continued on an outpatient basis.

The average stay for all patients decreased from 434 days in 1952 to 300 in 1955, with half the patients leaving in only 218 days in 1955. The relapse rate was low.

As a result, patients are now able to obtain

prompt admission to the sanitarium. The number admitted annually has increased by 50 per cent, and the number of patients obtaining chemotherapy at any one time has tripled. (*American Review of Tuberculosis and Pulmonary Diseases*, Dec. 1956.)

The Chicago trend has been noted across the United States. In 1946 there were 412 non-federal tuberculosis hospitals; in 1956 there were 315, representing a drop of 8,771 beds. The world-famous Trudeau Sanatorium at Saranac Lake, N. Y., oldest institution of its kind in the country, closed December 1, 1954, with an accompanying statement by its executive director, Dr. Gordon L. Meade, which said that "because of progress in tuberculosis drugs and surgery, most victims of the disease can now be treated nearer their homes." (*New York Times*, Nov. 30, 1954.)

The saving in productive time to countless tuberculosis patients who otherwise would have spent years of their lives in sanitoriums is not hard to calculate. The saving in money that would have been spent to operate the additional facilities, had not an effective means of controlling the disease been discovered, is a small indicator of the contribution of the chemical revolution in medicine.

Expectancy at Birth

Life expectancy of children born in the United States has increased from about 47 years in 1900 to over 69 years in 1956. In fact, life expectancy at birth has increased almost 10 years just since 1937. In the first decade of the antibiotic era—1944 to 1954—infant deaths declined 33 per cent, and maternal deaths 77 per cent.

Mental Hospitals

Tranquilizing drugs do not cure mental illness. But they do make patients more amenable to psychiatric therapy. In 1955, psychiatric hospitals cared for 54 per cent of the total number of patients hospitalized each day. But between April 1955 and April 1956, following widespread use of tranquilizers, there was a 23 per cent increase in discharges from mental hospitals in New York State. Increased discharge rates were also reported in Indiana, Illinois, Ohio, Tennessee, and South Dakota.

The most tangible result of the use of tranquilizing agents has been the marked improvement of the environment within the hospital. Physical restraint and seclusion have been reduced. Greater hospital freedom has been granted to patients. There is less use of the various shock therapies. The Veterans Administration reported a substantial cut in electric shock therapy as well as insulin

coma treatment during 1957. About half the psychiatric patients hospitalized by the Veterans Administration were being treated with tranquilizing drugs in 1957.

Hospital Productivity

The test of a hospital's productivity lies in basic human measures—how many patients are served, how many lives extended, and how much pain and disability can be avoided or reduced. When these measures were applied to Beth Israel Hospital of Boston—one rather typical metropolitan hospital—for the years 1932 and 1952, the results were impressive indeed.

These two years were representative of distinct eras in medicine and hospital care, i. e., before and after the current era of sulfa drugs, antibiotics, and other great advances in therapy and in broader understanding of the nature of disease.

During the period there was a decrease in the average length of stay per admission, from 12.8 to 9.8 days. The hospital's occupancy ratio rose from 70 per cent in 1932 to 93 per cent in 1952. The mortality rate declined by a third between 1932 and 1952—from 52 to 34 per 1,000 admissions. This saving in life occurred in spite of the higher average age of patients admitted during the latter year. (*Progress in Health Services, Health Information Foundation*, New York, Sept. 1957.)

The average length of stay in all non-federal short-term general and special hospitals has declined recently from 9.1 days in 1946 to 7.7 days in 1956. (*Journal of the American Hospital Association*, Guide Issue, part II, Aug. 1, 1957.)

Rise in Nutritional Level

Vitamins, the production of which amounted to 7,198,000 pounds in 1956, have helped to raise our nutritional level to the point where severe deficiencies are seldom seen in most sections of the country. The one-time necessity for placing pellagra patients in mental hospitals, particularly in the South, was practically eliminated with the discovery that niacin, one of the B-complex vitamins, cures the deficiency disease once caused by the dreary 3-M diet—meat, meal and molasses.

Mobilization Against Disease

Discovery in the laboratory is the first phase in the chemical revolution in medicine. But the step between laboratory discovery and mass distribution is not an easy one. The space must be bridged carefully and at a deliberate pace. Time is essential in the appraisal of new medicines, as it is in the conversion of laboratory procedures to production methods. Yet time is precious to the

disease-stricken patient, and an inevitable conflict exists.

But rapid and successful development is possible, too, and production of Salk polio vaccine furnishes an example of this. In the two and a half years following the announcement in April 1955 of the effectiveness of the vaccine for paralytic polio, five pharmaceutical manufacturers prepared 215 million cc's. (doses) which were released for public use. In October 1957, production was running at the rate of 12 million cc's. a month. This vaccine played a major part in a dramatic 80 per cent reduction in paralytic polio in the United States over the two year period. For the first nine months of 1957 there were only 1,576 paralytic cases reported, as compared with 5,241 for the same period in 1956, and 7,886 in the same period in 1955.

Production of Asian influenza vaccine in 1957 was an even swifter race against time. On May 22 the U. S. Public Health Service sent prototypes of the Asian strain of influenza virus to the six licensed influenza vaccine manufacturers for a start on development of a vaccine to protect the civilian and military population against the influenza strain then exploding into epidemics in the Far East. The first lots of vaccine, totaling 502,000 cc's. (doses), were released for use on August 12, just 82 days later. At the end of six months, on November 21, the amazing total of 48,877,624 cc's. had been released. Thus was recorded a truly remarkable pharmaceutical mobilization against disease, for a production cycle of about 50 days is necessary to produce one lot of vaccine.

Benefit from Veterinary Medicine

Hand in hand with the development of clinical medicine has come progress in veterinary medicine. The direction of effort is toward control of animal disease, more economy in animal production, and, ultimately, better nutrition for the general public.

Drugs and biologicals for the treatment of man and animal are basically the same. The pharmaceutical industry, recognizing the need for better ways to control animal diseases, is supporting veterinary research in university laboratories as well as carrying on research in individual company laboratories and on extensive research farms.

Cost of Medical Care

Improvement in the level of medical care brought on in part by the discovery and development of new pharmaceuticals over the past 20 years, has not been accompanied by an increase in cost out of proportion to the generally rising cost of living and higher real incomes which has taken place between 1936 and 1956. The percentage

U. S. Drug Research Sets All-Time High in 1958

Expenditures for medical and drug research of the pharmaceutical and medicinal chemical industry reached an all-time high of \$170,000,000 in 1958, it has been revealed by the Health News Institute. The industry spent \$127,000,000 in 1957.

The figures were disclosed by a survey conducted by the Pharmaceutical Manufacturers Association which reported that in 1958 the ethical pharmaceutical industry poured back about seven per cent of its total sales into research and development. The industry supported medical schools, hospitals, etc., or financed medical research in them, to the extent of \$20,560,000 in 1958.

increase for medical care has not been as great as that for food, personal care and clothing. The per cent of disposable income spent for medical care has changed little in the past 28 years.

Americans have consistently spent about the same proportion of their expendable incomes for medical care generally and for drug preparations and sundries specifically since 1929. Yet advances in medicine—perhaps most dramatically illustrated in drug discoveries—are making available today much better medical care for the same portion of the disposable income dollar.

The rise in the cost of hospitalization reflects both higher overhead costs and higher current operating costs, such as higher salaries and increased payrolls. Moreover, with the change in medical technology, the average stay in general hospitals has been considerably shortened, resulting in a heavier concentration of services per patient day because more service is usually required the first few days. However, by the end of 1956, almost 70 per cent of the civilian population had some protection against hospital costs through a prepayment plan. (*Monthly Labor Review*, U. S. Dept. of Labor, Bureau of Labor Statistics, Sept. 1957.)

Toward the Future

Research continues in the fight to conquer such ancient scourges as cancer, heart disease and arthritis. Pharmacy and the pharmaceutical industry is not static. It is concerned in a continuing effort, along with other members of the health team, toward a better life for all mankind.

More than 2000 Americans die every year from appendicitis, a statistic which could be brought close to zero if people secured earlier treatment.

Activities of County Societies . . .

First District

(COUNCILOR: CHARLES W. HOYT, M. D.,
CINCINNATI)

HAMILTON

Regular meetings of the Academy of Medicine of Cincinnati during February included the following subjects and speakers:

February 3—"Sexual Behavior," Dr. Wardell Pomeroy, director of field research, Institute for Sex Research, Indiana University.

February 17—"Everybody's Business; the Problem of Fallout and Radiation," Dr. Charles Wesley Shilling, acting director, Division of Biology and Medicine, U. S. Atomic Energy Commission, Washington, D. C. This was a joint meeting with the Council on Industrial Health of the American Medical Association, 19th Annual Congress on Industrial Health.

Many of the specialty sections of the Academy also held programs.

HIGHLAND

Dr. Thomas Hancock, of Washington C. H., addressed the luncheon meeting of the Highland County Medical Society held at noon January 7 at the Highlander restaurant, Hillsboro.

WARREN

Thomas E. Fox, M. D., Mason, was recently elected to the presidency of the Warren County Medical Society at a meeting held at the Golden Lamb Hotel in Lebanon.

Dr. Ray Simindinger, Lebanon, was elected vice-president; Dr. Dale Hubbard, Franklin, treasurer and Dr. Paul Ward, Pleasant Plain, secretary.

Third District

(COUNCILOR: FLOYD M. ELLIOTT, M. D., ADA)

ALLEN

Members of the Allen County Academy of Medicine met jointly with the Lima Life Underwriters Association on January 27. Speaker for the occasion was Dr. Gamber F. Tegtmeyer, member of the board of the Marquette University School of Medicine and medical director of the Northwest Mutual Life Insurance Company.

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

LUCAS

The February program in Lucas County included the following features:

February 5—Toledo Medical Library Association annual meeting.

February 13—Section on Pathology of the Academy; A Symposium on the Diagnosis and Treatment of Rabies.

February 20—Medical Section; "Staphylococcus Infections and Their Importance in Present-Day Treatment," Dr. Harry F. Dowling, professor, Department of Preventive Medicine, University of Illinois.

February 26-27—Postgraduate Lecture Series; "Problems of Peripheral Vascular Diseases," with the following speakers from the Department of Medicine, Mayo Clinic: Drs. Edgar A. Hines, R. W. Gifford, Jr., and John A. Spittel, Jr.

Officers of the Academy for 1959 are: Dr. M. A. Schnitker, president; Dr. Harland F. Howe, president-elect; Dr. Henry D. Cook, secretary; Dr. C. L. Felker, treasurer.

Fifth District

(COUNCILOR: GEORGE W. PETZNICK, M. D.,
CLEVELAND)

CUYAHOGA

A Symposium on Homotransplants was jointly sponsored on January 16 by the Academy of Medicine of Cleveland and the Cleveland Urological Society. The afternoon program included the following topics and speakers:

"Homograft Reaction of Skin and Thyroid," Dr. John D. Des Prez.

"Acceptability of Arterial Homografts in Humans," Dr. A. W. Humphries.

"Renal Homotransplantation to Portal Circulation," Dr. Lester Persky.

"Current Status of Bone Homografts," Dr. K. G. Heiple.

Moderator—Dr. Clifford L. Kiehn.

Following a social hour and dinner, the audience heard the guest speaker, Dr. Joseph E. Murray, plastic surgeon, Peter Bent Brigham Hospital and director of Surgical Research Laboratory, Harvard Medical School. His topic was, "Current Studies in Homotransplantation of Skin, Kidney and Bone Marrow."

LAKE

Two Lake County physicians were singularly honored during January for their years of dedicated service to their respective communities.

Dr. Willis H. Willis, who has been Lake County commissioner of health for the past five years, and is returning to Rhodesia, South Africa, was honored at a farewell dinner sponsored by the Lake County Board of Health, the Lake County Medical Society and the Lake County Reg-

(Continued on Page 418)

B. I. D.

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DARICON^{*}

oxyphenyclimine hydrochloride

TABLETS

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patient comfort

Natural Prolonged Action—The action of DARICON, a more potent and better tolerated anticholinergic, is consistently prolonged because it has a unique chemical structure and is not dependent on “mechanical” means (e.g., special coating, adsorption on ion-exchange resin).

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istered Nurses' Association. More than 200 guests attended.

Dr. Willis, with an M.D. from Western Reserve and a postgraduate degree from the London School of Tropical Medicine and Hygiene, served as a medical missionary from 1930 to 1939 at Mt. Silinda, in Southern Rhodesia. He served under the Congregational Church Mission Board.

Dr. Willis was presented with a purse by Mr. Carl Reeves, chairman of the Lake County Board of Health, who stated that "the polio program under Dr. Willis' direction has been outstanding."

Mr. Herman Higginbotham of the Lake County Chapter of the National Foundation for Infantile Paralysis, presented Dr. Willis with a plaque and a March of Dimes certificate of appreciation.

Dr. Robert A. Hingson, professor and director of anesthesiology at Western Reserve University, presented the program which brought into sharp focus Africa and its medical challenges. Dr. Hingson was part of a fifteen man survey team whose doctors, medical aides and other personnel spent three and one half months on the tour and traveled 45,000 miles by plane, ship, train, jeep and bus, ministering to the needy as well as making the survey.

His talk was illustrated with black and white and colored slides, many of them of Dr. Albert Schweitzer and his hospital and grounds, where the mission stayed for several weeks.

Dr. Herbert S. Wells, of Willoughby, was honored by the Willoughby Chamber of Commerce at a dinner on January 15, and presented with a plaque "for outstanding community service."

Dr. Wells was given tribute for his 32 years of medical practice here, during which time he has contributed in many ways to the welfare of the community.—Mrs. Owen A. McLaren, Executive Secretary.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D.,
YOUNGSTOWN)

COLUMBIANA

The Columbiana County Medical Society, meeting January 20 at the Hotel Wick in Lisbon, unanimously recommended that the sanitarian be retained by the Columbiana County Health Department.

The society also approved a health manual to serve as a guide to the superintendents of schools in the county.

Dr. Everett Hurteau, a neurosurgeon from Akron, addressed the physicians on "The Surgical Treatment of Parkinson's Disease." A film on operative techniques illustrated his talk.

Accompanying the Akron neurosurgeon was a

patient who had been restored to near normal activities through surgical treatment.

About 30 physicians attended the meeting.—*Salem News.*

MAHONING

The Mahoning County Medical Society held its annual banquet at the Tippecanoe Country Club, Youngstown, on January 31. Installation of new officers, previously announced, was a feature of the meeting. Following dinner and the brief ceremonies, doctors and their ladies enjoyed a social evening.

STARK

New meeting place for the Stark County Medical Society is the Mergus Restaurant, Canton, where the February 12 meeting was held. Speaker for this occasion was Dr. Robert M. Blizzard, assistant professor of pediatrics and assistant professor of medicine, Ohio State University. His subject was "Variations of Adolescence."

Scheduled for March 4 is a symposium on "Recent Developments in Diseases of the Kidney."

TRUMBULL

An event of the January 21 meeting of the Trumbull County Medical Society was presentation of a 50-Year Award to Dr. L. H. Marshall, Cortland. Presentation was made by Dr. Paul E. Noonan, president of the Society.

Eighth District

(COUNCILOR: WILLIAM D. MONGER, M. D.,
LANCASTER)

ATHENS

On January 13, 1959, the Athens County Medical Society, met at Mount Saint Mary Hospital to present 50 year pins to Dr. J. R. Sprague of Athens and Dr. L. D. Nelson of The Plains. Dr. W. D. Monger, Councilor for the District, was present and conducted the presentation, praising the faithfulness and tenacity of purpose of men who achieve this award.

After the program, group photographs were taken of the entire Society.—C. R. Hoskins, Secretary.

WASHINGTON

Dr. Thomas Morgan, Gallipolis, chairman of the Southeastern Ohio Regional Committee on Trauma of the American College of Surgeons, was guest speaker at the January meeting of the Washington County Medical Society in Marietta. His discussion was on the Cornell University auto crash study.

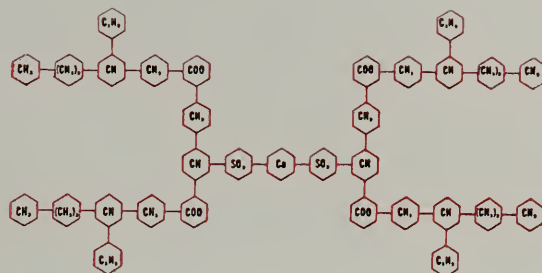
Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

GALLIA

The Gallia County Medical Society recently presented an opaque projector as a memorial to

NEW THERAPEUTIC CHEMICAL IN CONSTIPATION



Calcium Bis-(Dioctyl Sulfosuccinate)

The discovery by Wilson and Dickinson¹ at the University of Michigan that dioctyl sodium sulfosuccinate could correct constipation through fecal softening action marked a real advance in therapy. In cases of unimpaired bowel motility this new physico-chemical principle presented a new means of correcting bowel dysfunction without the need of catharsis.

Continuing research has now led to the development of a new therapeutic surfactant with more than double the surfactant effectiveness of the original dioctyl sodium sulfosuccinate.

This new substance, calcium bis-(dioctyl sulfosuccinate), reduces interfacial tension to a minimal value at a concentration of only 0.035 per cent. A minimal value of this order in dynes per centimeter requires 0.1 per cent or more of the older dioctyl sodium sulfosuccinate.

INTERFACIAL TENSION (Oil-Water Interface) <i>Calcium Bis-(Dioctyl Sulfosuccinate)</i>	
Dynes/cm.	Concentration
55.0	0.00%
13.3	0.01%
9.9	0.02%
8.4	0.03%
7.4	0.035%

Improved homogenization of the immiscible lipid and aqueous phases of the intestinal content depends upon maximum reduction of interfacial tension. The greatest degree of fecal softening is achieved with surfactant agents capable of reducing interfacial tension to minimal values. Calcium bis-(dioctyl sulfosuccinate) represents a markedly more effective surfactant agent since maximum surfactancy results from less than half the concentration of previously used surfactants.

DOSAGE:

DOXICAL 240 mg. SOFT GELATIN CAPSULES — for adults, one daily.

DOXICAL 50 mg. SOFT GELATIN CAPSULES — for children and adults with minimum needs, one to three daily.

1. Wilson, J. L., and Dickinson, D. G.: J.A.M.A. 158:261-263 (May 28) 1955.

This new chemical, definitely superior in surfactant action, is indicated in the treatment of chronic constipation where non-laxative fecal softening therapy is the preferred regimen.

The usual adult dose is 240 mg. daily. For children and adults with minimum needs, 50 to 150 mg. daily may be given.

DOXICAL

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CINCINNATI 3, OHIO

the late Dr. N. Howard Foster to the Gallia Academy Senior High School. Presentation of the visual aid to instruction was made by Dr. Thomas N. Morgan, president of the Society. Dr. Foster served many years as the school's physician.

HOCKING

Dr. George B. Watson of the Laurelville-Adelphi area was elected president of the Hocking County Medical Society at the annual organization meeting.

He succeeds Dr. H. M. Boocks, who was elected secretary-treasurer for the coming year. Dr. Petras Balsevicius was named vice president.

The medical society discussed the program to provide free polio shots to pre-school children whose families are unable to pay for the immunization.

During the past year, the medical society donated \$250 for such immunization, and the health department gave some 500 shots.

The doctors discussed possibility of PTA's or other civic organizations becoming interested in this program and providing funds for the free vaccine.—*Logan News*.

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

FRANKLIN

The Annual Meeting of the Columbus Academy of Medicine was held on January 21 at the Jai Lai Cafe. Guest speaker was Dr. W. W. Bauer, director of the Bureau of Health Education for the AMA, who spoke on "General Observations of Health Fairs."

KNOX

Dr. Richard Gomer, Mount Vernon physician, received an Ohio State Medical Association certificate for having practiced medicine 50 years in a ceremony at the Knox County Medical Society election meeting January 8 in the Alcove.

Dr. Gomer practiced medicine 30 years in his native Austria before coming to Mount Vernon 20 years ago.

The certificate was presented by Dr. E. H. Artman of Chillicothe, OSMA district councilor.

Dr. Henry Lapp was elected president, Dr. C. W. Trott was elected vice president, and Dr. Thomas Bogardus was reelected secretary-treasurer of the Knox County Medical Society for 1959.

Twenty-four physicians and their wives attended the dinner meeting.—*Mt. Vernon News*.

MADISON

The annual election meeting of the Madison County Medical Society was held on December 10 in London with W. T. Bacon presiding and

the following in attendance: Ayulo, Bacon, Hurt, Knapp, Maggied, Marcus, Postle, Rosnagle and Wolber.

After some discussion, a poll of the membership indicated that this Society is opposed to Amendment No. 2 to Chapter 4 of the OSMA By-Laws as approved by the House of Delegates at the 1958 Convention. In essence, this amendment requires that any resolution to be presented to the House of Delegates must be filed with the Executive Secretary of the OSMA at least sixty (60) days prior to the meeting of the House of Delegates, unless two thirds (2/3) or more delegates present vote to waive such requirement. Dr. Maggied, Society Delegate, was instructed to draw up a counter amendment for Society consideration and/or endorsement at a later meeting.

The desirability of physician participation in the formulation of the rules and regulations which govern high school athletic contests with a view to reduction of injuries was discussed in some detail. Dr. Maggied was asked to investigate current policies and practice, and to present specific suggestions for Society consideration at a subsequent meeting.

On request, the secretary was authorized to release for publication copies of the official minutes of meetings of this society or appropriate excerpts from same, and was instructed to provide regular news releases summarizing appropriate Society activities for the local press.

The chair previewed the program of the Society for the coming year and stated that much of the meeting time would be devoted to discussing and planning for participation in staff organization and operation of the proposed Madison County Hospital. It was the consensus of members present that it would be desirable to have as guest speakers selected physicians, administrators, board members and other officials having to do with staff organization and/or operation at other community hospitals, and the chair was authorized to invite

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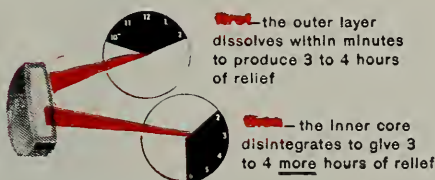
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One-half of this formula is in the outer layer, the other half is in the core.

Dosage: One tablet in the morning, mid-afternoon and in the evening, if needed.

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such individuals to address this group. In this connection, Dr. Postle was authorized to invite the County Health Commissioner to the January meeting.

The following members were nominated and elected for the indicated office: for President, W. T. Bacon; for Vice-President, J. Hurt; for Secretary-Treasurer, P. Wolber, for Councilor, J. Knapp; and for Delegate, Sol Maggied. There being no further nominations, it was moved, seconded and carried that the nominations be closed and that the above be declared unanimously elected by common consent.—*Paul G. H. Wolber, Secretary.*

PICKAWAY

Dr. Henry H. Swope, Circleville, recently at the annual election banquet of the Pickaway County Medical Society, was named president.

Dr. Warren Hoffman, Ashville, was elected vice president, Dr. E. L. Montgomery, Circleville, was named secretary-treasurer of the society.

Dr. Montgomery was also named delegate to the Ohio State Medical Association Annual Meeting. Dr. Ned B. Griner, Circleville, was named alternate delegate.—*Circleville Herald.*

ROSS

Dr. Richard Meiling, associate dean at Ohio State University College of Medicine, was the guest speaker at the meeting of the Ross County Medical Society at the McCarthy Hotel.

Dr. Meiling, a brigadier general in the Air Force Reserve, discussed "Medical Problems of the Space Age."

The meeting was attended by 31 physicians. Dr. Robert E. Quinn is president of the society.—*Chillicothe Gazette.*

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

ASHLAND

Members of the Ashland County Medical Society paid tribute to Dr. L. G. Sheets, Ashland physician for the past 40 years and Luzetta Yeater, nurse at Samaritan hospital for more than 20 years, at its annual ladies night meeting at the Terrace Hotel.

The Society presented both honorees transistor radios as tokens of esteem. Dr. Sheets announced his retirement from active practice to the group last night and was eulogized by Dr. Paul Kellogg, one of his colleagues in Ashland for many years.

Speaker of the evening was Dr. Henry Luidens, superintendent of the State Hospital at Lima. His topic was "The Psychology of Our Two Political Parties."—*Ashland Times-Gazette.*

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without stimulation
- restores natural sleep
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Deprol is unlike amine-oxidase inhibitors

- does not adversely affect blood pressure or sexual function
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Deprol is unlike central nervous stimulants

- does not cause insomnia
- produces no amphetamine-like jitteriness
- does not depress appetite
- has no depression-producing aftereffects
- can be used freely in hypertension and in unstable personalities

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: Each tablet contains 400 mg. meprobamate and 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl).

Supplied: Bottles of 50 scored tablets.

1. Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. 2. Current personal communications; in the files of Wallace Laboratories.

Activities of Woman's Auxiliary . . .

CHAIRMAN PUBLICITY COMMITTEE—Mrs. W. J. Horger,
1100 Ohio Ave., East Liverpool, Ohio
(See Page 294 for roster of officers.)

COLUMBIANA

The January meeting of the Woman's Auxiliary to Columbiana County Medical Society was held at the Masonic Temple at Lisbon on January 20. There were 19 present.

A motion was made and passed that Dena Evans be recommended for a national office.

Safety Chairman, Mrs. Peter Cibula, gave a report on Safety, passed out safety pamphlets to each member, recommended that all school teachers receive safety pamphlets and be requested to relay the program to the children. In this way a greater number of children could be reached at the least expense.

Dr. Janis Lauva was the guest speaker. He spoke on the Balkan Countries.

HAMILTON

On February 17 the Cincinnati Auxiliary enjoyed a style show in the Netherland Hilton Hotel. "A Trip to Japan" was the theme of the show in which members modeled spring and cruise-wear fashions. Mrs. George D. J. Griffin acted as commentator and Mrs. Makoto Yamaguchi added a festive note when she modeled her authentic Japanese gown. Mrs. Robert S. Heidt was in charge of the models.

Cocktails were served prior to the luncheon. The business meeting was conducted by the Auxiliary President, Mrs. Earl C. Van Horn. Members are looking forward to the March 17th meeting at the Hyde Park Country Club. The guest speaker will be the President of Miami University, Dr. John D. Millet whose topic will be "Education for Tomorrow." Mrs. Vinton E. Siler and Mrs. Charles Work are program chairman and vice-chairman respectively. Hospitality chairman is Mrs. Ralph Miller, with Mrs. Ralph Eddy acting as vice-chairman.

CUYAHOGA

Mrs. Frederick Rittinger, Cuyahoga's president, has announced that the Woman's Auxiliary

to the Academy of Medicine once again plans to distribute Family Health Record Books and the wallet size Personal Health Information Cards to the residents in the county.

These cards and booklets will also be delivered for the Auxiliary to all new Clevelanders in the area by the Welcome Wagon. Mrs. J. Kenneth Potter, public relations chairman, estimates that at least two thousand copies a month will be circulated through this medium.

Mrs. W. F. Boukalik, *Today's Health* Chairman, has also arranged with Welcome Wagon to introduce to the "New-Comers" *AMA's* magazine, and to leave a sample copy and a subscription blank.

The Cleveland Academy of Medicine has asked assistance of the Auxiliary, when they present a special all day program for the public entitled, "Rx for Traffic Safety." Mrs. John Budd, the Auxiliary safety chairman, will provide hostesses. Her committee will also help with dinner reservations, and the distribution of tickets. Mrs. G. C. Sternad, telephone committee chairman, will follow up calls and reservations.

DELAWARE

The Woman's Auxiliary to the Delaware County Medical Society has been active since its first meeting in October. Members of mothers clubs of the city were guests. Judge Henry Robinson was guest speaker.

The Auxiliary adopted the project for the year—that of furnishing favors for the local hospital patients' trays.

Regular meetings were held in November, December and January. The members made favors for the patients' trays. At Christmas time gifts were collected for the county hospital. These projects have created good public relations.

FAIRFIELD

January meeting, lunch. Hostess, Mrs. Boice Van Gundy in her home. Reports heard, legislation, safety, ways and means, recruitment, project, *Today's Health*.

Activities: The group agreed to provide funds

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COUNTRY HOME AND SCHOOL

For Mentally Deficient Boys — Ages 3 to 15

Mrs. H. A. Copeland, Director

for transportation of the student nurses to the Lancaster Branch College of Ohio University. Mrs. Van Gundy displayed and explained safety posters which she had on display in City Hall for one week. The next meeting will be a party to raise funds for AMEF.

MAHONING

The January 20th meeting of the Woman's Auxiliary to the Mahoning County Medical Society was a brunch held at the Pick Ohio Hotel with members of the Woman's Auxiliary to the Mahoning County Bar Association attending as guests.

William S. Pound was the guest speaker, illustrating with slides his talk on the work of the Mahoning County Society for Crippled Children and Adults.

In a short business meeting after the program, the Auxiliary voted to send \$300 to the American Medical Education Foundation.

The Auxiliary's Bowling League organized this year reports that at the middle of the bowling season Mrs. E. A. Shorten's team was in first place; Mrs. Bert Firestone's team in second place; and Mrs. A. R. Cukerbaum's in third place. Mrs. A. E. Rappoport leads the league with the highest bowling average.

RICHLAND

Thirty members were present when the Woman's Auxiliary to the Richland County Medical Society met for a luncheon-bridge at the Mansfield-Leland Hotel on January 5.

Mrs. C. H. Bell reported on personal health wallet cards. It was urged that both auxiliary and non-auxiliary members carry these, stressing the request that doctors give them to their patients.

The President, Mrs. Harry Wain, announced the nominating committee: Mrs. Paul Blackstone, Mrs. Carl Damron and Mrs. F. J. Heringhaus.

All members were asked to report on hours of volunteer service to any civic organization.

Mrs. Wain announced that a hair dryer had been purchased for the nurses home and on December 19 a ping-pong table and equipment was delivered to the home.

SCIOTO

Mrs. Rose Moore Gault opened her home for the January meeting of the Woman's Auxiliary to the Scioto County Medical Society.

Guest speaker for the initial 1959 meeting was Robert Edwards, chief of police.

Chief Edwards presented as his topic, "Civil Defense and Disaster," in which he stressed the urgent need of a paid director to set up the county-wide program.

The local police chief explained that "Ports-

mouth is one of the few cities in Ohio which does not have a defense director." He also reported that while Portsmouth has a partially operative plan for civil defense, some cities in the state have a defense and disaster plan in full operation.

Mrs. Ralph W. Armbrister, a guest, explained in detail the basement shelter which she and her husband have readied in their home in case of disaster.

Mrs. C. W. Wendelken read a memorial tribute to three deceased members.

A nominating committee was elected as follows: Mrs. Jerome Rini, chairman; Mrs. George W. Martin, Mrs. Samuel L. Meltzer, Mrs. H. M. Keil and Mrs. G. E. Neff.

At the social hour Mrs. Gault was assisted by Mrs. A. L. Berndt.

SUMMIT

The Pre-Health Days meeting of the Summit County Medical Society Auxiliary, guests from health agencies, and others concerned with health in Summit County, was held on February 3 in the University Club.

Dr. Bruno Gebhard, director of Cleveland Health Museum, spoke on "Live Longer and Like It." Dr. Gebhard sparked Akron's Health Days by sharing with auxiliary members and representatives of agencies who will be exhibiting on March 6, 7 and 9, in O'Neil's Auditorium, some of his vast experiences in promotion of public health.

Mrs. Edwin L. Mollin is chairman of Health Days.

TRUMBULL

The members of the Trumbull County Medical Auxiliary entertained guests and members of the Trumbull County Bar Auxiliary at a luncheon meeting on Thursday, January 15 at the ElRic. A short business meeting was conducted by the President, Mrs. John Grima. Mrs. Densmore Thomas asked for the cooperation of the members in a money raising project which her committee has planned for the American Medical Education Foundation. Each member is to have a small card party in her home before the first of March.

The speaker was introduced by Mrs. James Loney. Dr. Leonard Lovskin of the Cleveland Clinic gave a very entertaining talk on the subject, "The Tired Mother Syndrome."

A couple's chances of reaching a golden wedding anniversary have more than doubled since 1900, Health Information Foundation reports. About 150,000 couples now celebrate a golden anniversary each year, and another 750,000 have already had theirs.

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NOTE: BONADOXIN has also been shown highly effective in relieving nausea and vomiting associated with: anesthesia, radiation sickness, Meniere's syndrome, labyrinthitis, cerebral arteriosclerosis, and motion sickness.

Each tiny pink-and-blue BONADOXIN tablet contains:

Meclizine HCl (25 mg.) . . . for antiveriginous, antinauseant effects.

Pyridoxine HCl (50 mg.) . . . for specific metabolic replacement.

DOSAGE: usually one tablet at bedtime. Severe cases may require another dose on arising.

SUPPLIED: tiny pink-and-blue tablets, bottles of 25 and 100. Fruit-flavored, clear green syrup in 30 cc. dropper bottles.



Infant colic? BONADOXIN DROPS are antispasmodic . . . stop colic in 84% 8-10 without the risk of belladonna and barbiturates.

Each cc. contains:
Meclizine dihydrochloride . . . 8.33 mg.
Pyridoxine hydrochloride . . . 16.67 mg.

Dosage:

under 6 months	0.5 cc.	2 or 3 times daily, on the tongue, in fruit juice or water
6 months to 2 years	1.5 to 2 cc.	
2 to 6 years	3 cc.	
adults and children over 6	1 tsp. (5 cc.)	

References: 1. Goldsmith, J. W.: Minnesota Med. 40:99 (Feb.) 1957. 2. Groszkoss, H. H., et al.: Clin. Med. 2:885 (Sept.) 1955. 3. Weinberg, A., and Werner, W. E. F.: Am. Pract. & Digest Treat. 6:580 (April) 1955. 4. Crawley, C. R.: West. J. Surg. 8:463 (Aug.) 1956. 5. Tartikoff, G.: Clin. Med. 3:223 (March) 1955. 6. Dunn, R. D., and Fox, L. P.: Clinical exhibit. 7. Codling, J. W., and Lowden, R. J.: Northwest Med. 57:331 (March) 1958. 8. Dougan, H. I.: Personal communication. 9. Leonard, C. L.: Personal communication. 10. Steinberg, C. L.: Personal communication.



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American College of Chest Physicians Plans 25th Anniversary Meet

The American College of Chest Physicians will hold its Silver Anniversary meeting at the Ambassador Hotel, Atlantic City, June 3-7. The scientific program will include prominent speakers on all aspects of heart and lung diseases. In addition to formal presentations, there will be a number of symposia, round table luncheon discussions, postgraduate seminars, and motion pictures. Details may be obtained from the organization's office, 112 East Chestnut Street, Chicago 11, Illinois.

At ages 55-64 years, one in every five husbands is responsible for the support of one or more children under 18. About 280,000 youngsters are dependent on fathers who are 65 years of age or older.—*Metropolitan Life*.

Two More Appointments Made To AMA Staff

Dr. Franklin C. Yoder, Cheyenne, Wyo., has been named director of the AMA Division of Socio-Economic Activities. The division will include the Bureau of Health Education, Economic Research Department, and the Councils on Industrial Health, National Defense, Medical Service, and Rural Health. Dr. Yoder, who has been director of the Wyoming Department of Public Health since 1957, will immediately assume his duties on a part-time basis until July 1.

Edwin Patterson, Washington, D. C., is the new manager of the AMA Washington office. For the past 10 years, he has been director of the professional staff of the Veterans' Affairs Committee of the House of Representatives.

Mr. Patterson, who is 46 and a lawyer by profession, has already taken over his new duties.

CORNELL UNIVERSITY MEDICAL COLLEGE ANNOUNCES THE FOURTH ANNUAL POSTGRADUATE COURSE IN FRACTURES AND OTHER TRAUMA JUNE 8-13, 1959

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Metabolic Response to Injury
Dr. James A. Nicholas
Bone Metabolism in Fracture Healing
Dr. Melvin Horwith
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X-Rays in Fracture Treatment
Dr. Nathaniel Finby
Treatment of Shock
Dr. John M. Beal
Anaesthesia in Trauma
Dr. Joseph F. Artusio
Injuries to the Chest
Dr. Cranston W. Holman
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Report on Mental Health Conference in Chicago

Dr. Dwight M. Palmer, chairman of the OSMA Committee on Mental Health, represented the Association at the Fifth Annual Conference of Mental Health Representatives of the State Medical Associations sponsored by the AMA in November, 1958, in Chicago. Following is Dr. Palmer's report on the Chicago meeting.

Representatives were present from almost all of the 48 states. The agenda of the meeting consisted of five topics with sectional and group sessions. A brief report of the discussion and comments follows.

1. **The Problems of the Learning Deficits in Children.** This is a wide spread problem which should receive more medical and community support. It is estimated that 7 per cent of children have learning disabilities. The matter of accurate diagnosis was emphasized. Educational programs should be presented to practicing physicians. Schools for retarded children should be such and should not also include retarded adults or social delinquents. A separation of these types can best be carried out in all-purpose diagnostic centers for both out-patients and in-patients.

2. **The Communicability of Mental and Emotional Illness.** This is a relatively new area in medical thinking and the problem is largely at the research level at this time.

3. **Education for Psychiatric Medicine.** The discussions were concerned both with the teaching of medical students and the education in psychiatry for physicians not practicing psychiatry. It was stated that there should be further investigation of teaching methods and that lectures were probably the least effective technique. It was felt that the Woman's Auxiliary could make definite contributions to lay education if they were given professional advice.

4. **The Joint Commission on Mental Illness and Health.** The report of this commission indicated that the work of the organization had been hampered by lack of trained medical personnel.

5. **Mental Illness and Health in the Aged.** This is a rapidly expanding problem and there is every indication that its scope will increase in the future. There is no single answer to the question as to the type of service required by senior citizens. It is obvious that hospitalization is not the only answer. It is possible that many aged persons are in hospitals because society has failed to develop resources that can care for them outside of a hospital. It is believed that the older person should be kept in the hospital only as long as his symptoms cause distress.

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GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, Apr. 13. Vaginal Approach to Pelvic Surgery, one week, Apr. 27. General & Surgical Obstetrics, two weeks, Mar. 30.

MEDICINE—Two-week intensive course, May 11. Hematology, one week, May 25. American Board Review Course (Part II), one week, May 25. (A one week course for Part I applicants will begin on Sept. 14).

RADIOLOGY—Diagnostic X-Ray, two weeks, Apr. 27. Clinical Uses of Radioisotopes, two weeks, May 4.

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Kettering Memorial . . .

Famed Inventor's Son Plans \$4 Million Dayton Medical Center That Will Include 200-Bed General Hospital and Several Other Buildings

THE son of the late Charles F. Kettering, the famed inventor, has announced plans to develop a \$4 million medical center, including a 200-bed hospital, medical research building, health museum and quarters for the Montgomery County Medical Society.

Eugene W. Kettering said the Kettering Memorial Medical Center would be situated on the 90-acre Kettering estate located in Kettering Village adjacent to Dayton. It would include all of the estate except the residence and immediate grounds, which the family will continue to occupy.

Financing Plans

Financing of the project, according to Kettering, will not include public solicitation, but rather "friends and associates of my father (who) have indicated their wish to join with me in developing the medical center."

He said it is hoped to have construction under way within six months, and that the project will take two years to complete after contracts are awarded.

Hospital of 200 Beds

The 200-bed hospital is to be designed for future expansion to 400 beds as community needs develop. Kettering, who resides in Hinsdale, Illinois, has given a health museum to that community. He said the museum planned for the memorial center would be a facility for public education, housing medical displays and other educational aids. The building also would house the Montgomery County Medical Society.

The medical research building would offer facilities for patients as well as for advanced research.

Kettering said the new hospital will be privately administered, and will be operated on the open staff principle whereby any physician may practice there so long as he meets the necessary professional standards.

Advisory Personnel

Development of the project is to be under direction of the Montgomery County Foundation for Research and Education, with Kettering as Foundation chairman.

Physician members of the foundation include G. Douglas Talbott, M.D., Dayton, and Col. John Paul Stapp, M.D., chief of the Aero Medical Laboratory, Wright Air Development Center.

Members of a medical advisory board established by the Montgomery County Medical Society to assist the foundation include Drs. R. Dean Dooley, Second District Councilor; A. V. Black, Theodore L. Light, John R. Keys, A. J. Carlson, medical society president, and Mr. Robert F. Freeman, executive secretary of the medical society.

Want Medical School

The announcement brought about in the Dayton area renewed interest in the possibility of establishing a medical school there. A Dayton Area Chamber of Commerce committee is investigating the possibility of such a school, following previous work by the Montgomery County Medical Society.

Also, the Children's Hospital Society of Dayton has requested approval from the Chamber of a fund drive to establish a children's hospital.

Ohio State Surgical Association Will Meet in Cleveland, June 3-4

Members of the Ohio State Surgical Association are looking forward to another summer meeting and scientific lecture program.

The meeting will be held June 3-4 at the Statler hotel in Cleveland. Past-President John H. Lazzari is general chairman.

Speakers named for the program to date include: Drs. Robert Zollinger, George Crile, Jr., Stanley Hoerr, Michael Mason, Orvar Swenson and John Davis. Completion of the remainder of the program is expected soon.

In addition to the scientific sessions, the two-day program includes an afternoon of golf and an informal dinner dance.

Other Cleveland area committee members include: Drs. Maier M. Driver, Kent Brown, C. R. Jablonoski, William Neville, Norman Thiesen, Paul Mielcarek, R. B. Robrock, Richard Taylor, Regis McNamee, A. A. Pimsner, and Jac Geller.

Barney Shaffer of Toledo will assist the golf arrangements committee. Mrs. Kent Brown is chairman for ladies activities.

AMA's House of Delegates will request the Post Office Dept. to issue a memorial stamp commemorating the 150th anniversary of the first successful oophorectomy on record performed by Dr. Ephraim McDowell on Dec. 25, 1809, at Danville, Ky., on Jane Todd Crawford.

Actions in Congress . . .

Roundup of Events in National Legislative Body During Past Month Are Summarized Here as They Were Reported by the AMA Washington Office

WHAT'S been happening in the 86th Congress during the past month is commented on in the following report prepared by the Washington Office of the AMA.

After hearings, a subcommittee of the Senate Banking and Currency Committee reported favorably on a housing bill that contained provision for mortgage guarantees for proprietary nursing homes. Subsequently, the measure was passed by the Senate. The House is at work on another housing bill that also contains the nursing home loan section.

Keogh Bill Approved

Without bothering with hearings, the House Ways and Means Committee overwhelmingly approved the Keogh bill to encourage retirement plans for the self-employment. It acted in line with the committee's established procedure to quickly reapprove bills that passed the House the previous Congress, but not the Senate. The Keogh bill is identical with a measure that easily cleared the House last session but lost out in the Senate.

Legislation to extend the regular and doctor drafts four years rolled through the House. However, indications were the Senate would take its time and give careful consideration to the need for a four-year extension.

The Senate Labor and Welfare Committee, under the leadership of Chairman Lister Hill (D., Ala.), demonstrated its interest in legislation for the aged. Senator Hill named a subcommittee to make a full year's study of problems of the aged, taking in housing, employment and recreation, as well as medical aspects.

National Survey Proposed

Three members of the Senate standing health subcommittee, Senators Jacob K. Javits of New York, Clifford B. Case of New Jersey and John Sherman Cooper, all Republicans, asked Congress to authorize a two-year study of the health problems of the entire population. If approved by Congress, the investigation would look into the quality and quantity of health services, problems of extending health insurance, special problems of the aged and minority groups, and the distribution of health services.

Medicare has not been able to keep within the \$72 million "ceiling" recommended by Congress for the present year. Through the Navy it is

asking \$6 million more. In addition, Army and Air Force will shift funds to meet the bill, estimated at \$93.6 million. The budget asks \$89 million for next year, in expectation that restrictions begun in October will bring a saving of between \$4 million and \$5 million.

Medicine has won an argument within the new Federal Aviation Agency. As a consequence, FAA's civil air surgeon will assist the administrator in setting standards for fitness, direct physical examination and inspection programs, advise on research needs, and evaluate all of FAA's medical personnel plans.

Revised Cleveland Academy Medical Care Plan Now In Effect

A revised Cleveland Academy of Medicine Medical Care Plan offering payment-in-full for specified procedures up to a specified maximum to families earning \$6,000 or less per year is now in effect. The original plan went into effect in 1952 for families earning \$5,000 or less.

Some 80 per cent of the approximately 2,060 members of the Academy voted on the revised plan. Of those voting, 91 per cent indicated approval of the plan; 7 per cent expressed disapproval; 2 per cent expressed neither approval nor disapproval but raised various questions regarding their participation in the plan.

The plan is now being offered primarily by Medical Mutual of Cleveland but may be offered by any other insurance carrier which meets standards stipulated by the Academy.

In addition to raising the income level of eligible families, the fees allowed under the plan were raised on an average of 20 per cent. Obstetrical services are still covered on an indemnity basis—\$60.

Available coverage has been broadened in many instances. Medical services in a hospital will be reimbursed at a rate of \$15 for the first day and \$5 per day for the next 119 days. A special allowance of \$25 is made for each of the first two days hospital care for a case in which an extraordinary amount of time, skill and effort are required. Certain psychiatric treatments have been added. New surgical techniques are covered.

The cost of the plan is approximately 17 cents a day per family in groups. About 200,000 persons have been enrolled under the previous plan.

Look Magazine Criticized for Article on Hospitals

Dr. Edwin L. Crosby, director of the American Hospital Association, and Dr. F. J. L. Blasingame, executive vice-president of the American Medical Association, have taken issue with an article on practices in hospitals in the February 3 issue of *Look* magazine.

Dr. Crosby wrote a letter to Vernon C. Myers, the magazine's publisher, commenting on the article by Roland H. Berg, *Look* medical editor.

Dr. Crosby termed the article's opening sentence—"A hospital is not a fit place in which to be sick"—as "an outrageous misstatement." He said "This statement is disproved by an abundance of evidence; the growing acceptance by the public of the hospital as the place to get well; the direct relationship between the drop in maternal mortality rates and the increasing frequency with which hospitalization is sought for childbirth."

The study on five hospitals in California was sponsored by the California Medical Association. Dr. Crosby said 95 and 94 per cent of the patients in the two hospitals studied in greatest detail were generally satisfied with their care and treatment.

Dr. Blasingame speaking for the American Medical Association, said: "By taking isolated examples from a limited survey and drawing general inferences from them, *Look* not only has done a grave injustice to the medical profession and to hospitals but to the readers of the magazine. The blanket condemnation of all hospitals, based on a survey of five hospitals out of 5,640, is deplorable.

"While the article purportedly calls for better physician-patient relationships, it actually harms the patient's confidence in the care he will receive from his physician and in the hospital, so essential for the best in medical care.

"The article also violates the basic concepts of sound reporting. Matters such as these cannot be considered adequately or accurately covered until both sides of the question are reported with fidelity and without distortion.

Cincinnati Area GP's

"Disorders of Metabolism" was the theme of discussion at the January 18 meeting of the Southwestern Ohio Society of General Physicians. Speakers for the occasion were Dr. Harvey C. Knowles, Jr., associate professor of medicine, University of Cincinnati College of Medicine; Dr. Richard Goldsmith, assistant professor of medicine, UC; and Dr. Edward H. Rynearson, the Mayo Clinic, Rochester, Minnesota.

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Motion Picture Recordings on Aging. A selected list of auditory and visual materials primarily for use at conferences, meetings, classes and training programs concerned with the field of aging. (20 cents) Write Government Printing Office, Washington 25, D. C.

Bibliography on Staphylococcal Infection. Compiled by National Library of Medicine to help combat increased incidence of antibiotic-resistant staphylococcal infection. Write National Library of Medicine, Seventh Street and Independence Avenue, S. W., Washington 25, D. C.

The Patient Asks for a Medical Report. Pamphlet published by U. S. Department of Health, Education and Welfare, offering suggestions to physicians in preparing medical reports for use in Social Security disability determinations. May be obtained from district offices of Bureau of Old-Age and Survivors Insurance.

COMING MEETINGS

Ohio State Medical Association, 1959 Annual Meeting, April 21-24, Columbus.

American Medical Association, Annual Session, Atlantic, City, N. J., June 8-12.

AMA Law Department, Regional Medicolegal Conference, Hotel Cleveland, Cleveland, April 4-5.

AMA Rural Health Conference, Broadview Hotel, Wichita, Kansas, March 5-7.

Institute on Industrial Health, and Department of Ophthalmology, University of Cincinnati, Industrial Eye Problems, March 9-12.

Northwestern Ohio Medical Association, Findlay Country Club, October 7, all-day session; registration 9:00 a.m.; first speaker, 9:45 a.m.

Ohio Orthopaedic Society, Meeting, Akron, April 10, 11.

Ohio State Surgical Association, 1959 Annual Meeting, Cleveland, June 3-4.

Ohio State Radiological Society, Annual Meeting, Terrace - Hilton Hotel, Cincinnati, May 8-10.

Veterans Administration, Series of Clinical Courses, Wednesday Evenings, Cleveland.

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Committee on National Defense—Drew L. Davies, Columbus; C. C. Sherburne, Columbus; Robert Conard, Wilmington, members-at-large. **Subcommittee on Civil Defense**—C. C. Sherburne, Columbus, Chairman; Robert S. Heidt, Cincinnati; G. G. Floridis, Dayton; Charles H. Leech, Lima; Robert N. Smith, Toledo; Charles L. Leedham, Cleveland; Thomas Ulrich, Barberton; David K. Heydinger, Columbus; Frederick L. Schellhase, Youngstown; Joseph M. Strong, Elyria; P. A. Jones, Zanesville; Thomas W. Morgan, Gallipolis. **Military Advisory Subcommittee**—Drew L. Davies, Columbus, Chairman; Robert Conard, Wilmington, member-at-large; Ralph G. Carothers, Cincinnati; Homer D. Cassel, Dayton; Lester C. Thomas, Lima; A. A. Brindley, Toledo; Donald M. Glover, Cleveland; Albert E. Winston, Steubenville; Walter L. Cruise, Zanesville; Garnett E. Neff,

(Continued on next page)

STATE ASSOCIATION OFFICERS AND COMMITTEEMEN (Continued)

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Committee on Relationship Between Medical Societies and Voluntary Health Organizations—A. Macon Leigh, Cleveland, Chairman; Charles L. Leedham, Cleveland; Norman O. Rothermich, Columbus; Charles A. Sebastian, Cincinnati; Theodore L. Light, Dayton; Robert G. McCready, Akron; Max T. Schnitker, Toledo; Harry Wain, Mansfield; Carl F. Goll, Steubenville; Harold E. McDonald, Elyria; Michael C. Kolczun, Lorain; Paul A. Davis, Akron; R. E. Tschantz, Canton.

Committee on Rural Health—Robert E. Reiheld, Orrville, Chairman; J. Martin Byers, Greenfield; E. G. Caskey, Mineral Ridge; V. R. Frederick, Urbana; L. W. High, Millersburg; H. R. Mayberry, Bryan; Robert G. Smith, Proctorville; Kenneth Taylor, Pickerington; Harold C. Franley, Jefferson; Harold C. Smith, Van Wert; Jasper M. Hedges, Circleville; Benjamin C. Diefenbach, Martins Ferry.

Committee on School Health—Thomas E. Shaffer, Columbus, Chairman; Margaret E. Belt, Lima; Richard R. Buchanan, Wilmington; Walter Felson, Greenfield; Dale A. Hudson, Piqua; Charles L. Kagay, Dayton; Robert A. Lyon, Cincinnati; Charles H. McMullen, Loudonville; Carl L. Petersilge, Newark; Robert C. Markey, Bowling Green; William S. Rothe, Bowling Green; J. I. Rhiel, Port Clinton; H. B. Thomas, Gallipolis; J. W. Wilce, Columbus; Carl A. Wilzbach, Cincinnati; Frederick J. Dineen, Painesville; Aubrey L. Sparks, Warren; Paul D. Hahn, New Philadelphia; H. H. Hopwood, Jr., Cleveland.

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COUNTY SOCIETIES' OFFICERS AND MEETING DATES

FIRST DISTRICT

ADAMS—Samuel B. Sonkin, President, Main St., West Union; Alexander Salamon, Secretary, Seaman. 3rd Wednesday, April, June, August, October and December.

BROWN—Vytautas Karoblis, President, 410 Main St., Ripley; Charles William Hannah, Secretary, Sardinia. 1st Sunday, monthly.

BUTLER—Clyde G. Chamberlin, President, 300 Rentschler Bldg., Hamilton; Mr. Charles G. Greig, Executive Secretary, 110 N. Third St., Hamilton. 4th Wednesday of alternate months.

CLERMONT—Cecil F. Barber, President, Felicity; Harry M. Breuer, Secretary, 224 George St., New Richmond. 3rd Wednesday, monthly.

CLINTON—Robert M. Cronebaugh, President, 116 N. Broadway, Blanchester; John K. Williams, Secretary, 100 W. Main St., Wilmington. 2nd Tuesday, monthly.

HAMILTON—J. Robert Hudson, President, 152 E. Fourth St., Cincinnati 2; Mr. Edward F. Willenborg, Executive Secretary, 152 E. Fourth St., Cincinnati 2. 3rd Tuesday, monthly. September through May.

HIGHLAND—J. Martin Byers, President, 316 Midway, Greenfield; Kenneth Lyle Upp, Secretary, 136 S. Washington St., Greenfield. 1st Wednesday, monthly.

WARREN—Thomas E. Fox, President, 309 Reading Rd., Mason; D. Paul Ward, Secretary, Box 85, Pleasant Plain. 2nd Tuesday, monthly.

SECOND DISTRICT

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CLARK—William P. Montanus, President, 301 Home Rd., Springfield; Martin J. Cook, Secretary, 1054 E. High St., Springfield. 3rd Monday, monthly.

DARKE—Jesse L. Heise, President, Pittsburg; Emmett W. Arnold, Secretary, Court House, Greenville. 3rd Tuesday.

GREENE—Paul C. Vernier, President, 67 Xenia Drive, Fairborn; Quinten L. Erd, Secretary, S. Limestone, Jamestown. 2nd Thursday, monthly.

MIAMI—William W. Weis, President, 404 W. Wayne St., Piqua; John W. Gallagher, Acting Secretary, 407 W. High St., Piqua. 1st Friday, monthly.

MONTGOMERY—Alvin J. Carlson, President, 878 Reibold Bldg., Dayton; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Medical Bldg., Dayton 2. 1st Friday.

PREBLE—E. P. Trittschuh, President, 309 E. Main St., Lewisburg; Birna R. Smith, Secretary, 203 Commerce St., Lewisburg.

SHELBY—Clayton B. Conover, President, 316 S. Main Ave., Sidney; Ned A. Smith, Secretary, 739 Spruce St., Sidney. 1st Tuesday, monthly.

THIRD DISTRICT

ALLEN—Roger L. Tecklenberg, President, 700 Cook Tower, Lima; Thomas D. Allison, Secretary, 401 Steiner Bldg., Lima. 3rd Tuesday, monthly, except June, July, August.

AUGLAIZE—Robert J. Herman, President, 611 W. Mechanic St., Wapakoneta; Robert S. Oyer, Secretary, 310 Perry St., Wapakoneta. Called meetings.

CRAWFORD—Donald R. Wenner, President, 117 S. Poplar St., Bucyrus; Arnold Eicens, Secretary, 406 S. Sandusky St., Bucyrus. 3rd Thursday, monthly.

HANCOCK—M. Wesley Feigert, President, Ohio Bank Bldg., Findlay; Benjamin H. Saunders, Jr., Secretary, 1900 S. Main St., Findlay. 3rd Tuesday, monthly.

HARDIN—Raymond G. Schutte, President, 110 E. Columbus St., Kenton; Jack C. Lindsey, Secretary, 214 N. Main St., Kenton. 2nd Tuesday, monthly.

LOGAN—Charles A. Browning, Jr., President, 445 E. Columbus Ave., Bellefontaine; Paul E. Hooley, Secretary, N. Main St., DeGraff. 1st Friday, monthly.

MARION—Thomas N. Quilter, President, 1040 Delaware Ave., Marion; Robert L. Stuber, Secretary, 399 E. Church St., Marion. 1st Tuesday, monthly.

MERCER—Julius Schwieger, President, Fort Recovery; Terrence J. Kerrigan, Secretary, 204 W. North St., Coldwater. 3rd Thursday, monthly.

COUNTY SOCIETIES' OFFICERS AND MEETING DATES (Continued)

SENECA—Thomas W. Watkins, President, 34 W. Market St., Tiffin; Robert R. Schwalenberg, Secretary, 34 W. Market St., Tiffin. 3rd Tuesday, every other month.

VAN WERT—Jack H. Cox, President, 301 N. Washington St., Van Wert; Ralph E. Rasor, Jr., Secretary, 507 S. Washington St., Van Wert.

WYANDOT—Clarence B. Schoolfield, President, 206 S. Main St., Upper Sandusky; Franklin M. Smith, Secretary, E. Saffle Ave., Box 68, Sycamore. 2nd Tuesday, monthly, except July and August.

FOURTH DISTRICT

DEFIANCE—Thad J. Earl, President, 1132 E. Second St., Defiance; Francis M. Lenhart, Secretary, 207 Summit St., Defiance.

FULTON—Edwin R. Murbach, President, 224 N. Defiance St., Archbold; Robert A. Ebersole, Secretary, 203 DeGroff Ave., Archbold. 2nd Tuesday, monthly.

HENRY—Edwin C. Winzeler, President, 812½ N. Perry St., Napoleon; Thomas F. Tabler, Secretary, 332 Railway Ave., Holgate. 1st Tuesday, monthly.

LUCAS—Maurice A. Schnitker, President, 1006 Secor Hotel, Toledo 3; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Blvd., Toledo 10. 3rd Tuesday, monthly.

OTTAWA—Cyrus R. Wood, President, 115 Madison St., Port Clinton; Robert W. Minick, Secretary, 124½ W. Water St., Oak Harbor. 2nd Thursday, monthly.

PAULDING—Edythe C. Pritchard, President, 509 N. Williams St., Paulding; D. E. Farling, Secretary, Main St., Payne. 3rd Wednesday, monthly.

PUTNAM—Walter E. Martin, President, 135 N. High St., Columbus Grove; Will W. Moody, Secretary, Vaughnsville. 1st Tuesday, monthly.

SANDUSKY—R. Allen Eyestone, President, Gibsonburg; Paul E. Burson, Secretary, Cor. Southwest & Center St., Bellevue. 3rd Wednesday, monthly.

WILLIAMS—Robert W. Dilworth, President, Main St., Montpelier; E. K. Bell, Secretary, P. O. Box 466, Bryan. Monthly meeting date varies.

WOOD—Stewart J. Smith, President, 106 N. Main St., Bowling Green; Richard L. Pearse, Secretary, 320 S. Main St., Bowling Green. 3rd Thursday, monthly.

FIFTH DISTRICT

ASHTABULA—Lewis H. Roth, President, 80 S. Broadway, Geneva; Albin P. Urankar, Secretary, Ashtabula Gen. Hospital, Ashtabula.

CUYAHOGA—Chester R. Jablonoski, President, 7211 Broadway, Cleveland; Mr. Robert A. Lang, Executive Secretary, 2009 Adelbert Rd., Cleveland. 2nd Tuesday, monthly.

GEAUGA—George Dandalides, President, Chardon Medical Center, Chardon; Alton W. Behm, Secretary, 112 South St., Chardon. 2nd Friday, monthly.

LAKE—Richard W. McBurney, President, 124 S. St. Clair St., Painesville; Mrs. Owen A. McLaren, Executive Secretary, 1051 Cadle Ave., Mentor.

SIXTH DISTRICT

COLUMBIANA—William A. Kolozsi, President, 616 E. Seventh St., Salem; Leonard S. Pritchard, Secretary, 153 S. Main St., Columbiana. 2nd Tuesday, monthly.

MAHONING—M. W. Neidus, President, 318 Fifth Ave., Youngstown; Mr. Howard C. Rempes, Jr., Executive Secretary, 245 Bel-Park Bldg., 1005 Belmont Ave., Youngstown 4. 3rd Tuesday, monthly.

PORTAGE—Charles C. Whitsett, President, Robinson Memorial Hospital, Ravenna; Don P. VanDyke, Secretary, 607 E. Main St., Kent. 3rd Tuesday, monthly.

STARK—John R. Seesholtz, President, 1645 Cleveland Ave., N. W., Canton; Mr. E. M. Sprunger, Executive Secretary, 405 Fourth Street, Canton 2. 2nd Thursday, monthly, except May, June, July, August and September.

SUMMIT—Donald I. Minnig, President, 640 W. Market St., Akron; Mr. S. H. Mountcastle, Executive Secretary, 437 Second National Building, Akron. 1st Tuesday, monthly, September through June.

TRUMBULL—Paul E. Noonan, President, 238 N. Park Ave., Warren; Ralph H. Jamison, Secretary, 197 W. Market St., Warren. 3rd Wednesday, monthly.

SEVENTH DISTRICT

BELMONT—John A. Brown, President, Morristown; Bertha M. Joseph, Secretary, 100 S. Fourth St., Martins Ferry. 3rd Thursday, monthly.

CARROLL—Samuel L. Weir, President, 625 N. Market St., Minerva; Robert C. Lanzer, Secretary, 625 N. Market St., Minerva. 1st Thursday, monthly.

COSHOCTON—Lewis E. Smith, Jr., President, 729 Main St., Coshocton; Harold W. Lear, Secretary, 110 N. Seventh St., Coshocton. 2nd Tuesday, monthly.

HARRISON—Elias Freeman, President, 264 S. Main St., Cadiz; Janis Trupovnieks, Secretary, High St., Box 366, Hopedale.

JEFFERSON—Ernest L. Perri, President, 517 N. Fourth St., Steubenville; Jacob Mervis, Secretary, Sinclair Bldg., Steubenville. 2nd Tuesday, monthly.

MONROE—Byron Gillespie, Secretary, South Main Street, Woodsfield.

TUSCARAWAS—Chester A. Bennett, President, 533 Wooster Ave., Dover; George D. Woodward, Secretary, 201 Boulevard, Dover. 2nd Thursday, monthly.

EIGHTH DISTRICT

ATHENS—T. J. Najm, President, 422 W. Washington St., Nelsonville; Charles R. Hoskins, Secretary, Security Bank Bldg., Athens. 2nd Tuesday, monthly.

FAIRFIELD—Lloyd L. Kersell, President, 130 Union St., Lancaster; Arthur B. VanGundy, Secretary, 843 N. Columbus St., Lancaster. 2nd Tuesday, monthly.

GUERNSEY—Jesse B. Kellum, President, 840 Wheeling Ave., Cambridge; Thomas D. Swan, Secretary, 651 Wheeling Ave., Cambridge. 1st Thursday, monthly.

LICKING—Kurt J. Fleisch, President, 125 Hudson Ave., Newark; Jay Ross Wells, Secretary, 375 Granville St., Newark. Last Tuesday, monthly.

MORGAN—A. H. Whitacre, President, Chesterhill; C. E. Northrup, Secretary, Corner Main and Seventh St., McConnellsville. Called meetings.

MUSKINGUM—J. Herbert Bain, President, 67 W. Main St., New Concord; William A. Knapp, Secretary, 1025 Maple Ave., Zanesville. 1st Tuesday, monthly.

NOBLE—Charles F. Thompson, President, Caldwell; E. G. Ditch, Secretary, Caldwell. 1st Tuesday, monthly.

PERRY—Charles E. Bope, President, Somerset; O. D. Ball, Secretary, 203 N. Main St., New Lexington. Called meetings.

WASHINGTON—William R. Stewart, President, 407 Second St., Marietta; Donald S. Williams, Secretary, 222 Third St., Marietta. 2nd Wednesday, monthly.

NINTH DISTRICT

GALLIA—Thomas W. Morgan, President, Holzer Hospital, Gallipolis; Norman W. Pinschmidt, Secretary, Gallipolis Clinic, 52 State Street, Gallipolis. 3rd Thursday, monthly.

HOCKING—George B. Watson, President, Box 296, Adelphi; Howard M. Boocks, Secretary, Court House, Logan. Indefinite meeting dates.

JACKSON—Tom Washam, President, 35 Vaughn St., Jackson; Brinton J. Allison, Secretary, 267 Ralph St., Jackson. Called meetings.

LAWRENCE—Gerard C. Geswein, President, 1626 S. Sixth St., Ironton; George Newton Spears, Secretary, 2213 S. Ninth St., Ironton. Monthly meetings on call.

MEIGS—Charles J. Mullen, President, 210½ E. Main St., Pomeroy; Selim J. Blazewicz, Secretary, 112½ E. Main St., Pomeroy. Last Wednesday, monthly.

PIKE—Paul H. Jones, President, Stockdale; George W. Cooper, Secretary, Piketon. 1st Tuesday, monthly.

SCIOTO—Ralph W. Lewis, President, 1025 Ninth St., Portsmouth; Carl H. Laestar, Secretary, 2829 Gallia St., Portsmouth. 2nd Monday, monthly.

VINTON—Richard E. Bullock, President, McArthur; H. D. Chamberlain, Secretary, W. Main St., McArthur.

TENTH DISTRICT

DELAWARE—Max W. Livingston, President, 28 North Vernon, Sunbury; Edward C. Jenkins, Secretary, c/o Mrs. Mabel Barrett, Jane M. Case Hospital, Delaware. 3rd Tuesday, monthly.

(Continued on Next Page)

COUNTY SOCIETIES' OFFICERS AND MEETING DATES (Continued)

FAYETTE—H. Wm. Payton, President, 36 S. Main St., Jeffersonville; Marvin H. Roszmann, Secretary, 107 N. North St., Washington C. H. 2nd Tuesday, monthly.

FRANKLIN—James L. Henry, President, 244 E. Park St., Grove City; Mr. William Webb, Executive Secretary, 79 East State Street, Columbus 15. Meetings in January, February, March, May, September, November and December.

KNOX—Henry T. Lapp, President, 4 Public Square, Mt. Vernon; Thomas L. Bogardus, Secretary, 50 Public Square, Mt. Vernon. Quarterly meetings.

MADISON—William T. Bacon, President, 40 E. First St., London; Paul G. H. Wolber, Secretary, 40 E. First St., London. 2nd Wednesday, monthly.

MORROW—Andrew Maciurak, President, 119 E. Main St., Cardington; William S. DeFinger, Secretary, Marengo. First Tuesday, monthly.

PICKAWAY—Henry H. Swope, President, 233 N. Court St., Circleville; Edward L. Montgomery, Secretary, 108 Seyfert Ave., Circleville. 1st Friday, monthly.

ROSS—Robert E. Quinn, President, 30 N. Walnut St., Chillicothe; G. Howard Wood, Secretary, 134 W. Main St., Chillicothe. 1st Thursday, monthly.

UNION—Paul R. Zaugg, President, 130 N. Maple St., Marysville; May B. Zaugg, Secretary, 130 N. Maple St., Marysville. 2nd Tuesday, monthly.

ELEVENTH DISTRICT

ASHLAND—R. Lee Schafer, President, 203 Maple Street, Ashland; Wayne C. Smith, Secretary, 140 Claremont Ave., Ashland. 1st Friday, monthly, except July, August.

ERIE—Richard F. Hoffman, President, Providence Hospital, Sandusky; Edward P. Gillette, Jr., Secretary, 410 Columbus Ave., Sandusky. Monthly meeting date varies.

HOLMES—Clyde Bahler, President, Walnut Creek; Luther W. High, Secretary, R. F. D. 4, Millersburg. 2nd Wednesday, monthly.

HURON—Walter A. Drury, President, Box 269, Willard; John V. Emery, Secretary, Box 269, Willard. 2nd Wednesday, March, June, September and December.

LORAIN—Denis A. Radefeld, President, 209 Sixth St., Lorain; Mrs. C. Ruth Zealley, Executive Secretary, 311 Elyria Block, Elyria. 2nd Tuesday, monthly.

MEDINA—Robert E. Smith, President, 403 East Liberty St., Medina; William G. Halley, Secretary, 115 Bank Street, Lodi. 3rd Thursday, monthly.

RICHLAND—Riley E. Frush, President, 36 S. Mulberry St., Mansfield; James O. Ludwig, Secretary, 336 Sturges Ave., Mansfield. 3rd Thursday, monthly.

WAYNE—Ralph I. Cottle, President, 230 N. Market St., Wooster; Robert E. Schulz, Secretary, Wooster Community Hospital, Wooster. 2nd Wednesday, monthly.

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References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

Schering

The Physician's Bookshelf

(Books received from publishers. *The Journal* is not obligated to list herein every book received. It will try to list those which appear to be of greatest interest.)

* * *

Privileged Communications Between Physician and Patient, by Clinton DeWitt, professor of law, Western Reserve University. (\$11.50, *Charles C. Thomas, Publisher, Springfield, Ill.*) This book, written by one of Ohio's leading attorneys and educators and based on 30 years' experience in trial and appellate courts, is a comprehensive yet practical treatise. It should be helpful to the trial lawyer and trial judge and should give the physician an understanding of privilege and its restraints to physicians. No textbook dealing exclusively with testimonial privilege has hitherto been available. The scope of the book is revealed by the following chapter headings: The common law doctrine of testimonial privilege applicable to particular confidential relationships; physician-patient privilege statute; model code of evidence and the uniform rules of evidence; policy of the privilege; nature of the privilege; construction of statute; what law governs; medical persons protected by the privilege; relationship of physician and patient; what communications and information are privileged; mode of attempted introduction immaterial; actions and proceedings in which privilege may or may not be invoked; pre-trial proceedings; trial practice; waiver of the privilege; waiver resulting from commencement of certain actions and proceedings; and waiver by conduct.

The Chemical Prevention of Cardiac Necroses, by Hans Selye, M. D. (\$7.50, *The Ronald Press Co., New York 10, N. Y.*) A summary of investigations by the author, including many hitherto unpublished experiments, on the production and prevention of cardiac necroses by chemical means. As Dr. Selye has pointed out: "Of all the observations made in our laboratory since 1936 on the somatic effects of stress, this strikes me as the one which holds the greatest promise of being clinically useful. So many types of acute cardiac failure caused by experimentally induced cardiac necroses or inflammation have been prevented by electrolytes, that I believe this type of treatment offers interesting possibilities of applicability, particularly in the prevention of acute cardiac death following stress. However, the cooperative effort of many laboratories and clinics will be required to accomplish this." The object of this monograph is to coordinate data in the light of newly acquired knowledge about the electrolyte-steroid-cardiopathies so there can be a better insight into the

complex relationships between electrolytes, steroids and stress, believed to be fundamental for the understanding and prevention of many diseases.

Recent Trends in Chronic Bronchitis, by Neville C. Oswald, M. D. (\$7.50, *Essential Books, Inc., 16-00 Pollitt Drive, Fair Lawn, New Jersey.*)

Population in Its Human Aspects, by Harold A. Phelps and David Henderson. (\$6.00, *Appleton-Century-Crofts Company, Inc., New York 1, New York.*)

Current Therapy 1958, by Howard F. Conn, M. D. (\$12.00, *W. B. Saunders Company, Philadelphia 5, Pa.*)

Obstetrics and Gynecology, by J. Robert Willson, M. D., Clayton T. Beecham, M. D., Isador Forman, M. D., and Elsie Reid Carrington, M. D. (\$10.75, *The C. V. Mosby Co., St. Louis 3, Mo.*)

Essentials of Pediatrics, by Philip C. Jeans, M. D., F. Howell Wright, M. D., and Florence G. Blake, R. N. (\$6.00, Sixth edition, *J. B. Lippincott Co., Philadelphia 5, Pa.*)

Communicable Diseases; A Textbook for Nurses, by Albert G. Bower, M. D., Edith B. Pilant, R. N., and Nina B. Craft, R. N. (\$7.50, Eighth edition, *W. B. Saunders Co., Philadelphia 5, Pa.*)

Emergency Treatment and Management, by Thomas Flint, Jr., M. D. (\$8.00, Second edition, *W. B. Saunders Co., Philadelphia 5, Pa.*)

Negroes and Medicine, by Dietrich C. Reitzes. (\$7.00, *Harvard University Press, Cambridge 38, Massachusetts.*)

The Edge of Tomorrow, by Thomas A. Dooley, M. D. (\$3.75, *Farrar, Straus and Cudahy, Inc., New York 3, N. Y.*)

Cardiovascular Collapse in the Operating Room, by Herbert E. Natof, M. D., and Max S. Sadove, M. D. (\$6.00, *J. B. Lippincott Co., Philadelphia 5, Pa.*)

Frontiers in Cytology, by Sanford L. Palay. (\$9.75, *Yale University Press, New Haven 7, Connecticut.*)

Cold Injury, Ground Type; The Medical Department, U. S. Army, World War II, by Colonel Tom F. Wayne, MC and Michael E. DeBakey, M. D. (\$6.25, *Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C.*)



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Average dosage is 1 teaspoonful daily. Available in bottles of 4 and 16 fl. oz.

Each teaspoonful (5 cc.) contains:

L-Lysine HCl	300 mg.
Vitamin B ₁₂ Crystalline	25 mcgm.
Thiamine HCl (B ₁)	10 mg.
Pyridoxine HCl (B ₆)	5 mg.
Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
Sorbitol	3.5 Gm.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York



Washington Roundup

News from the Nation's Capital of Interest to Physicians; Developments in Medical and Health Fields

Recently released National Health Survey showed that about 16,738,000 men, women and children spent an average of 8.6 days in general hospitals (chronic cases excluded) during 12-month period ended June 30, 1958. Most frequent admission was childbirth, followed by respiratory conditions as second most frequent. Six of 10 admissions involved surgery, NHS said.

* * *

Selective Service director has taken strong exception to suggestion of National Advisory Committee to Selective Service that Ready Reservist physicians vital to medical schools and hospitals should shift to Standby Reserves. General Hershey charged in letter to AMA President Gundersen that the committee exceeded its authority.

* * *

National Institutes of Health awarded during January total of 811 research grants and 217 fellowships with combined value of \$14,243,065. These included 345 new projects, the remainder granted for continuing support of existing projects.

* * *

People to People Health Foundation, Inc., is receiving growing support for its move to send a floating medical center on a goodwill mission to Southeast Asia. President Eisenhower has pledged to make available the hospital ship USS Consolation for the project.

* * *

Department of Health Education and Welfare has awarded first contract under its new patent policy permitting the contractor to patent and sell drugs or other chemical substances developed under government contract. The \$505,000 contract went to Upjohn Co. to develop, test and produce antibiotics and other drugs possibly effective in treatment of cancer.

* * *

During 1957, according to Social Security Administration estimates, American workers had total income loss of \$7.5 billion because of non-work-connected, short-term illness and first six months of long-term disability. About 26 per cent of income loss was paid in benefits under government and non-government sick leave and disability insurance programs.

Status of Hill-Burton program on December 31, 1958, showed in its 12-year history total of 4,315 projects approved at estimated cost of \$3,642,634,800 with U. S. share amounting to \$1,126,007,345. Report said 3,993 of the projects are in operation or under construction, encompassing 170,040 beds, 1,073 health units and miscellaneous facilities.

* * *

Pharmaceutical Manufacturers Association has called on Federal Government to devote most of its medical research funds to basic research and training new scientists, "rather than to applied research and development," with highest priority going to training additional science teachers and research personnel.

* * *

Food and Drug Administration is demanding that food labels carry specific names of chemicals being added to foods. One reason is that allergists need to know exactly what their patients are eating.

* * *

AMA Washington office has completed a survey showing that 361 physicians have served in Congress since 1774, 14 were state or territorial governors, and several led troops in battle.

* * *

Scientists in National Institute of Allergy and Infectious Diseases have demonstrated that mosquitoes and other insects can transmit Shope fibromas over a long period of time, so that they now appear to be "the most likely natural vectors" of these tumors.

* * *

New Civil Air Surgeon for the newly created Federal Aviation Agency will have responsibility of setting fitness standards for airmen, traffic controllers and other personnel; supervise national network of physical examinations, a function using thousands of private practitioners; strive to improve efficiency of aviation medical examiners, encourage research in aviation medicine, develop and conduct internal health and medical programs for FAA personnel, and miscellaneous duties.

* * *

Americans now see their doctor about five times a year, twice as often as 30 years ago.

IN URTICARIA AND PRURITUS

VISTARIL*

HYDROXYZINE PAMOATE



A PSYCHOTHERAPEUTIC ANTIHISTAMINE

(as designated by A.M.A. Council on Drugs, 1958)

SPECIFIC ANTIHISTAMINIC ACTION in the treatment of a variety of skin disorders commonly seen in your practice.

"While some of the tranquilizers are only partially effective as far as antiallergic activities are concerned... [hydroxyzine] has been found, by comparison, to be the most potent thus far..."¹

"The most striking results were seen in those patients with chronic urticaria of undetermined etiology."²

PLUS

PSYCHOTHERAPEUTIC POTENCY for the relief of anxiety and tension.

The psychotherapeutic effectiveness of hydroxyzine (VISTARIL) was confirmed in a series of 479 patients suffering from a wide variety of dermatoses, including atopic dermatitis, neurodermatitis, psoriasis, lichen planus, nummular eczema, dyshidrosis, pruritus ani and vulvae, and rosacea. "Adverse reactions were minimal."³

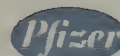
RECOMMENDED ORAL DOSAGE: 50 mg. q.i.d. initially; adjust according to individual response.

VISTARIL Capsules: 25 mg., 50 mg., 100 mg.

VISTARIL Parenteral Solution: 10 cc. vials and 2 cc. Steraject® Cartridges. Each cc. contains 25 mg. hydroxyzine (as the HCl).

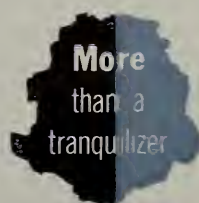
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You and Your Public

Every Individual Physician Should Support His Medical Society Grievance Committee

“**H**OW do we get our individual members to support our Grievance Committee? We have a Grievance Committee but some of our members don't want to let the public know anything about it.” Those two statements, made at the recent OSMA County Officers Conference, point up the fact that there still are physicians who fail to realize the value of this public relations “must.”

Call it grievance, mediation, judicial, professional relations, public service or ethics committee, it is just as important to the individual doctor as to his medical society. It is important to him because it:

Provides the physician with an impartial board of his peers to judge the validity of charges made against him by another person.

Provides the patient who feels he has been wronged the opportunity to present his case, thus making the patient realize that medicine looks upon him as an individual with rights.

Provides the physician with means of protecting himself against another physician whose unethical acts may reflect upon him and the profession.

Provides all concerned the means of settling differences amicably and satisfactorily.

Support Is Vital

The effectiveness of these provisions is measured in direct ratio to support of the grievance procedure by the community's physicians.

Also, to be effective, the Grievance Committee should be made known to the public. How else can the aggrieved patient make use of the committee if he is not aware that it exists?

Where the individual physician has been unjustly criticized or condemned, it is to his benefit as well as the profession's good that his record be cleared. Thus, the committee is a protective mechanism for the wrongfully accused physician.

Where the aggrieved patient is shown, through thorough, impartial and impersonal investigation by the Grievance Committee, to have a valid, bona fide complaint, the committee affords opportunity to act against the physician who has failed to keep the concepts of fellow members of his profession.

Stature Increased

The stature of the individual physician is increased in the eyes of his patients when the pa-

tients know that he supports and conducts himself within the bounds of these concepts.

There often is the case where the patient who files a complaint involving fees learns that he has received something of value far in excess of the fee which prompted his complaint.

There is the case where the Grievance Committee reviewed such a complaint and determined that the patient was not aware of the extensive surgical and medical treatment he had received. The committee further felt that the physician would have been justified in charging a considerably higher fee. The committee wisely called in the patient and explained in detail the extent of his treatment, pointing out that the fee was well below average for such cases.

The patient soon realized that he was out of bounds, that he had done an injustice to his personal physician. His apologies were profuse.

Fortunately for the physician, he had a strong Grievance Committee. He had failed to heed the admonition all physicians must continuously bear in mind, namely, to invite the patient to discuss the fee in advance. The Grievance Committee was there to step into the gap created by this oversight.

Not a Whitewash

The individual physician, on the other hand, should not look upon his Grievance Committee as a means of whitewash. He should expect it to function impartially and impersonally. He should further support it by submitting any evidence he may have in a grievance action, whether it involves himself or another physician.

This evidence may help to exonerate the accused physician or to substantiate charges against him. Whichever the evidence may do is not up to the individual physician to decide. He should leave this decision with the committee for it is the committee's function to evaluate any and all evidence.

The individual physician must bear in mind that the function of the Grievance Committee is not to throw stones. Its function is to hear, investigate and evaluate judiciously complaints and misunderstandings, and to attempt amicable adjustment or reconciliation.



running noses



and open stuffed noses orally

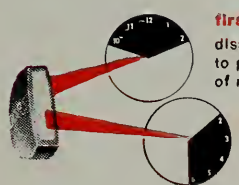
with TRIAMINIC, the oral nasal decongestant

- in nasal and paranasal congestion
- in sinusitis
- in postnasal drip
- in allergic reactions of the upper respiratory tract

safer and more effective than topical medication

- reaches *all* respiratory membranes systemically
- avoids "nose drop addiction"
- presents no problem of rebound congestion
- provides longer-lasting relief

Relief with Triaminic is prompt and prolonged because of this special timed-release action . . . beneficial effect starts in minutes, lasts for hours.



first—the outer layer dissolves within minutes to produce 3 to 4 hours of relief

then—the inner core disintegrates to give 3 to 4 more hours of relief

Each TRIAMINIC Tablet provides:

Phenylpropanolamine HCl . . . 50 mg.
Pheniramine maleate . . . 25 mg.
Pyrilamine maleate . . . 25 mg.

One-half of this formula is in the outer layer, the other half is in the core.

Dosage: One tablet in the morning, mid-afternoon and in the evening, if needed.

Triaminic[®]

Also available: For the occasional patient who requires only half dosage: timed-release TRIAMINIC JUVELETS. Each Juvelet is equivalent to $\frac{1}{2}$ of a Triaminic Tablet.

For those patients who prefer liquid medication: TRIAMINIC SYRUP. Each 5 ml. tsp. of this palatable syrup is equivalent to $\frac{1}{4}$ of a Triaminic Tablet.

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In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

DANGER WHEN WASHINGTON BECOMES THE MANAGER

Here is something to clip and paste in your hat, doctor.

Earl L. Butz, Ph. D., Dean of Agriculture, Purdue University, and former undersecretary of agriculture, warned the AMA's National Conference on Rural Health at Wichita, Kansas, March 5:

"The real danger from big government comes when Washington begins to take over direction of the managerial function in our economy, and begins to allocate resources and products on an arbitrary basis, rather than on the basis of personal preference guided by free prices in a free market, or guided by the desires of local people. When this occurs, all kinds of strange things follow."

He admonished his audience, "We must strive ever to preserve a proper relationship between our local activities and government. We must always keep private enterprise and private initiative the **senior** partner, and government the **junior** partner. It would be easy to reverse that relationship. There are many who would change it. We must be ever vigilant that our local communities assume the responsibilities put upon them by our private enterprise system. Otherwise, government will become the **senior** partner. This is inherent in the very nature of government.

"One of the great challenges facing all of us is to see that our economy is not dominated by government—that government helps rather than displaces private enterprise. We can do this only if we are willing to throw our influence on the side of keeping government the servant of all of us—not our master.

"We can do this only if we are willing to step forward and assert our God-given right to be master of ourselves and of our own destiny."

PROFESSIONAL COURTESY WORKS BOTH WAYS

If it happens in Cincinnati, it probably happens elsewhere in Ohio—maybe in your city.

We're talking about the matters referred to in the following article from the Acadogram of the Cincinnati Academy of Medicine, entitled "Professional Courtesy":

"It works both ways. Medical decisions should be made by physicians; legal decisions by lawyers. Complaints were received in the Academy Office

about a comparatively few physicians who tell their patients about the amount of damages that should be recovered from the defendant for the plaintiff's injuries. When the lawyer for the plaintiff recommends a settlement for a lesser sum because of other factors in the case, he has difficulty with the client.

"Also, a physician should not promote a particular lawyer. It is better procedure to suggest that the patient-client select his own lawyer or apply to the Reference Service of the Cincinnati Bar Association.

"It is advisable *not* to say 'You don't need a lawyer to file a claim against an insurance company.' Recently, a physician told his patient not to consult a lawyer for this purpose and it was later discovered that the patient permitted the statute of limitations to run out against the claim and the patient-client had no recourse. The patient blames the physician for his loss. Public relationwise and professionally, this is a foolish risk.

"If members avoid doing these things, it will assist the Standards of Practice Committee of the Academy of Medicine in their meetings with the Cincinnati Bar Association."

The above is good advice. If followed, better relations with the legal profession will ensue.

OFF-BASE LETTERS TO THE EDITOR

Probably one of the most alarming developments in the newspaper field is the failure on the part of too many editorial page directors to police the department known as letters to the editor. Why they should do so is apparent to those who are familiar with the contributions on health and medical subjects found in such departments, some of which are "unadulterated hogwash," as one observer has stated.

The newspaper profession itself is disturbed. An example is an article by John DeMott of the *Kansas City Star* in a recent issue of the Sigma Delta magazine, *The Quill*.

Here are some pertinent comments from DeMott's article:

"Most of the material forced to compete against letters to the editor for that precious space is the product of professional journalists carefully trained and experienced in years of reporting public affairs from an objective standpoint.

"Is the editor justified in sacrificing the fruits



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Provides balanced nutritional values

- ① Fibre-free **HYPOALLERGENIC** formula.
- ② An excellent formula for regular infant feeding.
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SOYALAC helps solve the feeding problem of prematures and infants requiring milk-free diet.

Strikingly similar to mother's milk in composition and ease of assimilation, babies thrive on SOYALAC.

Clinical data furnish evidence of SOYALAC'S value in promoting growth and development.

Protein of high biologic value is obtained from the soybean by an exclusive process.

Free Booklet and Samples

A request on your professional letterhead or prescription form will bring to you complete information, and a supply of samples. Please address the Loma Linda Food Company, Arlington, California, or Mount Vernon, Ohio.

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of such labor to offer the religious bigot, political partisan or just plain eccentric character a springboard for his propaganda? Much of the thought expressed in letters to the editor represents a distortion of demonstrable truth, and in some cases a brazen disregard of the facts.

"By magnifying such ignorance, the newspaper does a double disservice, for it also must hold out an equal amount of legitimate information to print the off-base letter.

"The editor's note, pointing out the error of each such statement, allegedly takes care of the situation. But does it? Doesn't it still rob the responsible observer of an additional opportunity to report to his public.

"Let me repeat. I'm not opposed to letters to the editor. * * *

"But as a 'faithful reader,' let me appeal to the editors of letters to the editor to please guard their columns heroically against the assault of the boob and the ignoramus, aggressive through their legions may be.

"It seems to me that in fairness to those dedicated to Sigma Delta Chi's search for truth, the editor should enforce equal standards upon the letter he receives in his mail.

"It should contribute something really constructive toward an understanding of the particular subject, or else the space should be reserved for other information that can meet such a standard."

The foregoing points up the real need for mighty close liaison between the local medical society and the local press—not just the reporting staff but the editor, as well. In all probability, once the editor understands the disservice he allows his paper to perform by publishing inflammatory letters from irresponsible persons, he will take steps to correct the situation.

GUIDANCE NEEDED AS PUBLIC HEALTH AGENCIES EXPAND

Magazine of the Ohio Tuberculosis and Health Association makes this very significant statement:

"Time was when the public expected little from its health department besides communicable disease control and sanitary service. Today there are strong demands for school health programs, adult health education, dietary counseling, vision and hearing testing, and above all for good institutions to take care of sufferers from long term disease, mostly elderly citizens. A few health departments have begun pilot programs and have mobilized their community to make at least a beginning in measuring the dimension of the problem and planning first steps to meet it."

This is further evidence of why it is so important for the medical profession through the Ohio

State Medical Association and the various County Medical Societies to have the closest relationship possible with state and local public health agencies. The public health agencies need, and should receive, guidance as they venture into new fields. We have a feeling they will welcome counsel from the medical profession. Is your County Medical Society ready to do the job?

PUT YOURSELF IN SHOES OF CUSTOMER, DOCTOR

In our opinion the following comment in a recent issue of the *AMA News* makes a lot of sense. There's no discounting the fact that usually an informed patient will not be a disgruntled patient. Read the comments and act accordingly:

"For years the only information appearing on a physician's bill was the notation, 'For Professional Services,' and the total sum owed.

"But today doctors realize that patients expect to receive statements with a break-down of services provided.

"The doctor who wants to put himself in the patient's place need only imagine how he would feel if he received a bill from a medical supply house which states only: 'For supplies received . . . \$150.' The MD wants to know what he bought and when. So does the patient.

"Itemized bills help patients understand the value of the services received. Consequently they are more likely to accept them as fair charges."

AMA Periodical Loan Service Yours For the Asking

If you wish to consult an article in a medical journal which you cannot borrow locally, the AMA Library is ready to help you.

What is the Periodical Lending Service? Individual issues from a file of about 1,600 different journals covering the past ten years are available for loan.

Who is eligible? Members of the AMA and individuals in the U. S. and Canada who subscribe to its scientific periodicals.

May librarians request loans? Yes, if name and address of eligible borrower is given.

How should requests be made? Since periodicals are not bound, give month or day date, page and author as well as name of journal, volume number, and year.

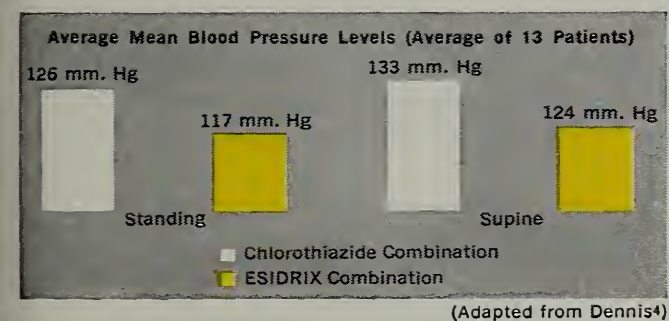
What are charges? None to members. 15 cents for each item to subscribers.

How should letters be addressed? Library, American Medical Association, 535 N. Dearborn, Chicago 10, Illinois.

Esidrix^{T.M.}

(hydrochlorothiazide CIBA)

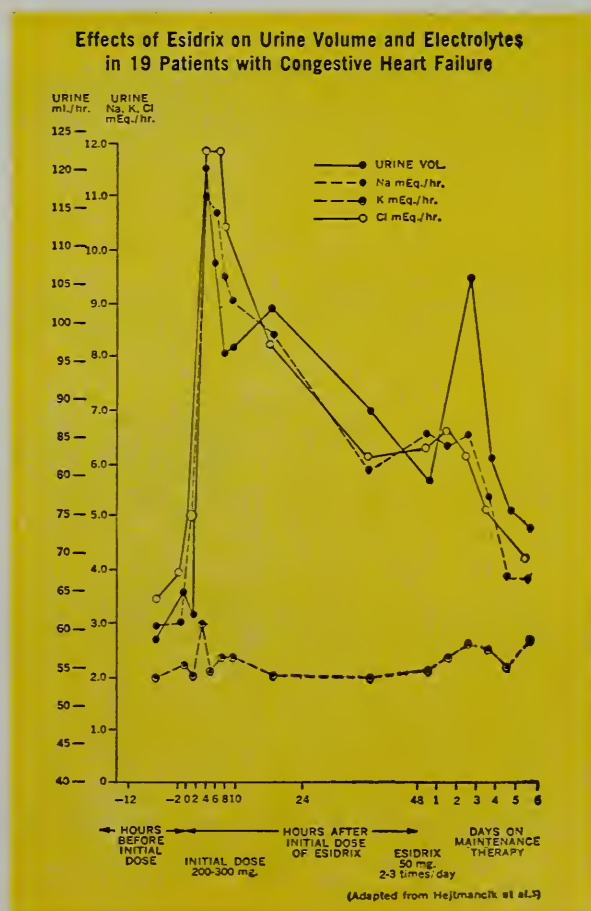
Produces greater average reduction in blood pressure: Eleven of 13 hypertensive patients⁴ were treated initially with a chlorothiazide-mecamylamine-reserpine combination (10 patients had 1000 mg. and 1 patient 500 mg. chlorothiazide daily); 1 patient had been treated with hydralazine and 1 had no previous medication. Nine were then transferred to an Esidrix-mecamylamine-reserpine combination and 4 to an Esidrix-reserpine combination for periods of 3 to 7 weeks (12 patients had 100 mg. and 1 patient 50 mg. Esidrix daily). Average mean blood pressure levels were recorded in the standing and supine positions. As shown in graph below, left, there was a further drop in blood pressure after patients were transferred to Esidrix.

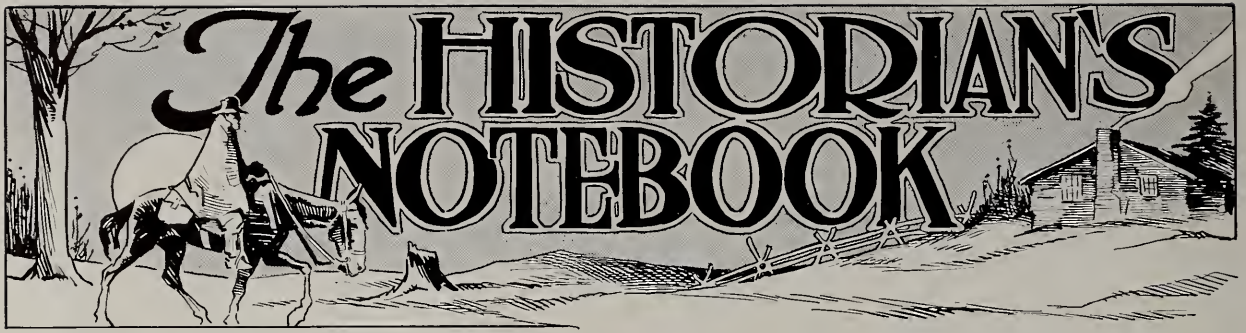


Exceptional safety . . . reduced likelihood of electrolyte imbalance: While Esidrix markedly increases sodium and chloride excretion, it has far less effect on excretion of potassium (see chart at right) and bicarbonate. Hence, there is little likelihood of disturbing electrolyte balance when recommended procedures are followed.

DOSAGE: Esidrix is administered orally in an average dose of 75 to 100 mg. daily, with a range of 25 to 200 mg. A single dose may be given in the morning or tablets may be administered 2 or 3 times a day.

SUPPLIED: Tablets, 25 mg. (pink, scored); bottles of 100 and 1000. Tablets, 50 mg. (yellow, scored); bottles of 100 and 1000.





U. S. Army Medical Service Contributions To Civilian Health and Medicine

IN January 1918 the Army's Central Medical Research Laboratory for the study of medical aspects of flying was established at Mineola, Long Island, New York. From this Laboratory grew the school of Aviation Medicine at Randolph Air Force Base near San Antonio, Tex., which became an Air Force responsibility when the Air Force was established as an independent component of the Department of Defense and separated from the Army. The work of medical officers engaged in Aviation Medicine has benefited both military and civilian aviation.

Maj. Fernando E. Rodriguez of the Army Dental Corps was one of the first to isolate one of the organisms causing tooth decay. He is regarded by members of the dental profession as one of the greatest contributors to this subject since Muller, the German investigator 25 years earlier.

Capt. John Sayre Marshall was another outstanding dentist. He was the author of several textbooks on dentistry, did original work in dental pathology and technic, and in 1884 organized the Northwestern Dental School.

Veterinary Medicine

Maj. (later Brig. Gen. and Chief of the Army Veterinary Corps) Raymond A. Kelser in 1928 developed a greatly improved vaccine for use against rinderpest, the "cattle plague." This immunization proved to be of tremendous value to the economy of the Philippine Islands and elsewhere in the world. He discovered that equine encephalomyelitis—the "Kansas horse plague"—was transmitted by mosquitoes, and proved that the protozoan parasite—*Trypanosoma evansi*—is a vector of surra, a uniformly fatal equine disease. He introduced a rabies vaccine in which the virus is inactivated by chloroform. He is the author of a well-known veterinary textbook and numerous scientific articles. After his retirement in 1946 from the Army he became Dean of the School

● This is the third and last of a series of articles about the contributions of the United States Army Medical Service to civilian health and medicine. Articles No. 1 and 2 appeared in the February and March issues of *The Journal*. The material was compiled by the office of the Surgeon General, Technical Liaison Office, Washington, D. C., and released in July, 1957.

of Veterinary Medicine at the University of Pennsylvania.

Among other Army veterinarians who were outstanding for their investigations of animal diseases was Col. John H. Kinter, who, in collaboration with Lt. Col. Rufus L. Holt of the Medical Corps, established equine osteomalacia as due to a nutritional deficiency and preventable by mineral supplement. During World War II Colonel Kinter conducted an extensive survey of the animal disease situation and advised on international animal quarantines in the Central and South American countries through which the Pan American Highway now runs.

In 1930 Lt. Col. George C. Dunham of the Army Medical Corps published *Military Preventive Medicine*—a comprehensive textbook of basic information necessary to the practice of preventive medicine in the Army. The usefulness of this excellent book, however, is not limited to the Army alone; it is a ready reference for public health measures pertaining to civilian communities.

Advances in Army research were put to the test when the Civilian Conservation Corps was created in 1933. The health of more than two and one-half million men enrolled in the CCC was under the care of the officers of the Army Medical Service. The health record achieved was outstanding. It was the first time in history that so large a group of young men had been brought together under camp conditions with no serious outbreak

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a Burroughs Wellcome 'SPORIN'...*

'CORTISPORIN'®

brand OINTMENT

Combines the anti-inflammatory effect of hydrocortisone with the comprehensive bactericidal action of the antibiotics.

OINTMENT: Tubes of $\frac{1}{8}$ oz. and $\frac{1}{2}$ oz. (with applicator tip) for ophthalmic or dermatologic application.

OTIC DROPS: Bottles of 5 cc. with sterile dropper.

Provides comprehensive bactericidal action effective against virtually all bacteria likely to be found topically.

'NEOSPORIN'®

brand ANTIBIOTIC OINTMENT

OINTMENT: Tubes of $\frac{1}{2}$ and 1 oz. and tubes of $\frac{1}{8}$ oz. with ophthalmic tip.

OPHTHALMIC SOLUTION: Bottles of 10 cc. with sterile dropper.

NEW { **LOTION:** Plastic squeeze bottles of 20 cc.
POWDER: Shaker-top bottles of 10 Gm.

'POLYSPORIN'®

brand ANTIBIOTIC OINTMENT

Offers combined antibiotic action for treating conditions due to susceptible organisms amenable to local medication.

OINTMENT: Tubes of $\frac{1}{2}$ oz., 1 oz. and $\frac{1}{8}$ oz. (ophthalmic tip).



BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.

of epidemic disease. When war came in 1941 the experience gained in caring for large groups of men in the CCC proved invaluable.

In May 1943 Capt. Stanley F. Erpf, an Army dental surgeon attached to the 30th United States General Hospital in England, initiated research in the use of plastic compounds used in making artificial dentures for the making of artificial eyes. So realistic are these plastic eyes that they have every color of natural eyes, move like real eyes, and do not have a staring look. They are low in cost, unbreakable, and technicians among Army enlisted personnel can learn to make them in 30 days, in contrast to the six or seven years it takes a glass blower to become skilled in the making of glass eyes. Dental Corps personnel also pioneered in the making of plastic noses, ears, and chins.

Rehabilitation

Similarly, the Prosthetics Laboratory at the Walter Reed Army Medical Center has been very successful in rehabilitating amputees. Artificial limbs are so cleverly constructed and fitted that the wearers are difficult to spot. The Laboratory has developed a functional artificial hand capable of doing practically everything a natural hand can do, and at talking distance not recognized as being a prosthetic device. The Army Medical Service sent laboratory technicians to Korea to assist the Koreans in rehabilitating their amputees.

Typical of the readiness of the Army to assist communities in distress was the making available of more than 500,000 doses of typhoid prophylactic to the Red Cross in the flood relief of the Ohio Valley in 1937. Besides providing the vaccine, the Army also placed its personnel, equipment, and transportation as needed to facilitate the relief service.

In February 1949, Dr. Joseph E. Smadel, of the Army Medical Service Graduate School of the Walter Reed Army Medical Center, reported on the use of chloramphenicol in treating typhus fevers. This report was the result of many years of study at the School, and was field tested in Malaya in the first half of 1948. So successful have chloramphenicol and other broad-spectrum antibiotics been in treating rickettsial diseases that widespread control measures formerly used can be markedly curtailed, since there is practically no danger of death occurring in cases which do develop. Rocky Mountain spotted fever in the central Atlantic states or boutonneuse fever in some Mediterranean areas are two endemic diseases where such treatment may be practiced.

In burn research, the Army Medical Service has learned the importance of saline solutions, plasma and whole blood in treating severely burned patients. However, in the event of an atomic bomb-

ing or other large-scale disaster there probably would not be enough dressings to meet the need. In this eventuality Army Medical Service experiments in the exposure method of treating burns could be vitally important to the civilian population. Results so far obtained by this burn treatment method are highly satisfactory.

But the contributions made by the U. S. Army Medical Service have not been in curative medicine alone.

Weather Bureau Pioneers

Before the Weather Bureau was set up, the Army kept the country's meteorological records. James Tilton, Surgeon General from 1813 to 1815, pioneered in this work when he directed hospital surgeons to record weather conditions—the beginning of systematic meteorological observations in this country. This work was continued by the Army Medical Service until 1870, when Army Surgeon Albert J. Myer (for whom Ft. Myer was named) was appointed first chief of the Army Signal Corps, and these duties were transferred to that Corps, where they remained until the present Weather Bureau was established in 1890.

Legal medicine has been advanced through the work of Col. Calvin H. Goddard, who made extensive studies of the identification of projectiles. He devised a technique for helping authorities to determine the precise manner in which gunshot victims met death. His work has proved of great value to law-enforcement agencies throughout the country.

As America expanded westward many Army medical officers spent their off-duty time in advancing the knowledge of the natural sciences of the areas in which they were serving. They made contributions in many fields: anthropology, ethnology, the study of fish and reptiles, large and small animals, the flora, the earth and its formations, and the weather. Ethnology and anthropology, for example, received early and comprehensive data on the Indian from Army medical officers.

An examination of the *Annals of Medical History*, *Medical Life*, and the *Bulletin of the History of Medicine*, at John Hopkins, shows that no group has contributed more writings on the medical history of this country than the officers of the Army Medical Service.

Thus, while the primary responsibility of the U. S. Army Medical Service is to conserve the health and strength of the Army, it has made the world a healthier place in which to live.

The Service may be proud of its contribution to civilian medicine and to American health during the past 181 years.

The Ohio State Medical Journal

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No. 4

PERRY R. AYRES, M. D., *Editor*

CHARLES S. NELSON,
Managing Editor — Bus. Mgr.

R. GORDON MOORE,
Asst. Managing Editor

The Use of Pre-Frontal Lobotomy (Grantham Technic) In Chronic Neuroses and Psychoses

JAMES L. SAGEBIEL, M. D.

Introduction

THOSE psychoneuroses and psychoses refractory to all types of psychiatric treatment have long been a challenge to our therapeutic resources. All types of therapy have been aimed at them and most have been found ineffective.

Ever since Egas Moniz¹ opened up the field of psychosurgery with his classical lobotomy in 1936 there have been repeated attempts on the part of investigators to focalize a specific lesion which would eliminate the abnormal symptoms and at the same time retain the personality intact. Thus, neurosurgical attacks on the frontal or temporal lobes, the cingular gyrus and the thalamus have been made by various methods.

Penfield and Cameron² performed gyrectomies of the frontal lobes with no better results than with the classical lobotomy. Rylander and later Paul et al., performed medial incisions of the frontal lobes and found them a bit more favorable. Scoville did orbital undercuttings and later performed medial temporal lobotomies and uncotomies with unimpressive results. Livingston with the autonomic connections of the anterior cingular gyrus and its pressor effect on the cortex in mind, isolated the cingular cortex. The results were encouraging. Lewis, Landers and King reported on a large series of topectomies. Since most of their patients were deteriorated schizophrenics, little improvement resulted. Spiegel and Wycis performed thalamotomies with indifferent success.

Jasper showed there were thalamocortical tracts

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which indicated a specific participation of the thalamus in the complex integrative functions of the brain.

Over the years it has been shown that practically all areas of the neocortex receive projection fibers from the thalamus. The majority of the affective fibers in the thalamocortical tract pass through the ventromedial quadrant.

In July 1951, Grantham³ reported a series of cases in which prefrontal lobotomy for relief of pain was produced by electrocoagulation of the ventromedial quadrant. Since then, he has expanded his work⁴ to include mental cases with excellent results except in deteriorated schizophrenics. McIntyre, Mayfield and McIntyre⁵ used the same technic and emphasized the need to make anxiety the criterion for the selection of patients.

Electrocoagulation of the ventromedial quadrants as designed by Grantham was the technic used in this series of cases.

Material

The patients were selected primarily because of their refractoriness to electroshock therapy and because of disabling symptoms of anxiety or hostility. Other cases were accepted without preliminary electroshock therapy because it was not feasible (detachment of the retina or advanced

cerebrovascular disease). Our material consisted of 24 patients from private practice, none of whom was deteriorated. There were nine schizophrenics (36.4 per cent). There were four each of manic-depressive psychosis, obsessive-compulsive neurosis and phobic reactions (17 per cent each). There were three involutional psychoses, two of which were depressives and one paranoid; all had cerebrovascular disease (12.6 per cent).

The sexes were equally divided. The average age of the males at the time of lobotomy was 48 with an age range of 22 to 62; the average age of the females was 42 with an age range of 19 to 71. The average duration of the present illness prior to lobotomy was:

	Average	Range
9 Schizophrenics	6 yrs.	8 mo. to 15 yrs.
4 Manic-depressives	7 yrs.	3 to 14 years.
4 Obsessive-compulsives	9 yrs.	7 mo. to 15 yrs.
4 Phobics	6 yrs.	3 to 13 yrs.
3 Involutional psychoses	7 yrs.	3 mo. to 10 yrs
Total	7 yrs.	18 mo. to 13 yrs.

Thus, it can be seen that this is a group of patients with a long duration of their illness prior to lobotomy. They had little hope for a happy and useful future without some drastic form of therapy.

The average follow-up was 28 months.

Technic

The anesthetic used was Pentothal® Sodium with intratrachial general anesthesia.

With the patient in the supine position two burr holes were placed 8 cm. above the glabella and 2 cm. lateral to the midline. By ventricular cannulae 5 ml. of air were placed in the anterior horn of each lateral ventricle. The cannulae were then withdrawn and the Grantham needles, insulated except for 1 cm. of their tips, were placed slightly anterior to the anterior horns and parallel to the midline. Each was advanced until it struck the base of the skull and was then withdrawn 1 cm. in order to avoid the gray matter. Anteroposterior and lateral x-rays were taken to determine the position of the needles. If this position was not satisfactory they were withdrawn, replaced and rechecked by x-ray. When their position was deemed satisfactory a coagulating current was applied for 30 seconds after which they were withdrawn 1 cm. and the current again applied for 30 seconds. The needles were then removed.

If, at this time, they did not show adherent coagulated brain tissue one could expect an unsuccessful result but if there was coagulated brain tissue adherent to the needles the electrocoagulation was considered adequate. The skin incisions were closed over tantalum buttons with two layers

of interrupted silk sutures. The object of the coagulation was to effect a lesion approximately 2 by 2 cm. in the ventromedial quadrant of both frontal lobes avoiding the gray matter of the cortex. By using an electrocoagulating current the possibility of hemorrhage was minimized.

Immediate postoperative side effects were slight confusion and drowsiness with mild pyrexia clearing in one or two days. All patients were up and about within 24 hours and usually quite comfortable. A remote effect for one to three months in both successful and unsuccessful cases was lessening of initiative and indifference to resuming full activities, such as return to work.

Method of Evaluation

In my opinion it is impossible to statistically evaluate the results of this procedure on a variety of nosological entities. Each case should be evaluated individually by comparison with its own preoperative disability.

Nevertheless, as all do, I have attempted to arrange a sliding scale expressing the results in percentages of normality: (1) When the patient was free of his former disabling symptoms and had made a good socio-economic adjustment he was listed as 90 per cent of normal; (2) when the patient retained some of his symptoms but was not disabled thereby and was able to make a good socio-economic adjustment, he was listed as 70 per cent; (3) when the symptoms were less intense than before operation but at times became disabling both socially and economically, the patients were rated at 50 per cent; (4) when the patient was so disabled as to make only a home or hospital adjustment requiring constant supervision the result was considered poor and the percentage was 30 per cent; (5) the one death in this series will be discussed later.

Results

Thirteen of the 24 patients (55 per cent) were graded 90 per cent of normal; five made good immediate recoveries and maintained their gain consistently for an observation period of 23 to 39 months. Three of these were phobic reactions, one an obsessive-compulsive and the other a catatonic schizophrenia. Three were graded 70 per cent immediately postoperatively but over a period of 20 to 37 months gained up to 90 per cent. Two of these were paranoid schizophrenias and one a manic-depressive psychosis. Two patients had an immediate result listed as 50 per cent but after 32 and 19 months respectively, had gained up to 90 per cent; one was a manic-depressive psychosis, the other a severe compulsive neurosis. Both patients are now gainfully

employed. Three patients had good immediate results of 90 per cent but dipped to 30 or 50 per cent and then gained back to 90 per cent after 19 to 33 months. Two were compulsive neurotics and another a schizo-affective schizophrenic.

Four patients reached only 70 per cent of normality; one an hysteric who later developed into a paranoid schizophrenic. She got a good immediate result of 90 per cent but relapsed to 70 per cent and required maintenance electroshock therapy. This treatment, however, allowed her to continue on her job as a schoolteacher. Three of them, two of whom were paranoid schizophrenics and one a phobic reaction, had poor immediate results but gradually over 12 to 30 months improved to 70 per cent of normality. One patient attained only 50 per cent, a severe manic-depressive depression of 14 years' duration who relapsed twice during his 31 months of observation but came out of each depression with additional electroshock therapy; he is now on a 50 per cent level.

Of five who reached only 30 per cent of normality after 12 to 45 months postoperative observation, one was a severe manic-depressive manic, with a strong paranoid trend in a psychopathic personality complicated by alcoholism. He had 26 electroshock treatments (ESTs), then two lobotomies, then 50 more ESTs over a period of two years. He got a good immediate result of 90 per cent after each lobotomy but relapsed to 30 per cent. He is now in the Dayton State Hospital. Two were elderly women aged 66 and 71 years. They had involuntional psychoses of a paranoid type with cerebrovascular disease. They both made fair to good immediate recoveries but gradually deteriorated to 30 per cent.

Another patient who attained 30 per cent of normality was a severe pseudoneurotic schizophrenic with an intense compulsion to utter obscene words. After 38 ESTs he had two lobotomies but made a poor adjustment after each one. Twelve months later he was substituting a shrill whistle for the obscene words but still compulsively would utter words referring to the menses. Another was a paranoid schizophrenic of 8 years' duration, a woman of 48 who made a good 70 per cent recovery after her lobotomy but has since deteriorated after 45 months to a precarious home adjustment.

One patient died, a male aged 57, who had had two cerebral thromboses, one on each side, followed by a severe reactive depression. He had been ill about three months. He died suddenly 12 days postoperatively at home, probably of a medullary thrombosis. No autopsy was allowed.

The family, however, was satisfied that he had improved as far as his depression was concerned prior to his death.

In summary, one can say that 13 of the 24 (55 per cent) had excellent results and another four (17 per cent) were greatly improved. They were symptom free, or practically so, and had made good social and economic adjustments. In this series of cases the involuntional psychoses, three in number, did poorly.

Complications

Other than the death previously detailed, there was one complication that arose, as shown in the following case report.

Case Report

The patient, a male, age 59, had had glaucoma since 1950. In June, 1953, while doing heavy wrench work as a plumber, he developed a detachment of the retina. He then began anxious rumination in regard to his eyes. In October, 1955, he developed a severe obsessive-compulsive reaction with intense anxiety and constant reminiscing on past mistakes or fancied errors. There was preoccupation with details in relating events. He indulged in compulsive ritualistic acts. He wanted repetitious verification of everything. He was unable to make decisions and had a fear of being alone. There was excessive self-recrimination and self-condemnation. Ataractic drugs and psychotherapy had no effect.

Because of the history of retinal detachment it was felt that electroshock therapy was contraindicated. A Grantham lobotomy was performed June 6, 1956, after which he was quiet, relaxed and pleasant. There were no subjective or objective evidences of anxiety or tension and no compulsive rituals. Eight days postoperatively he was discharged symptom free from the hospital.

Within two weeks he began to have a recurrence of his anxiety and compulsive behavior. By August, 1956, his misophobia had become intolerable. October 3, 1956, he had his second lobotomy. For 24 hours he was in good spirits and free of his anxieties and compulsions but then he had a grand mal seizure after which he was in a confused restless state with the left pupil slightly larger than the right. The deep tendon reflexes were hyperactive but equal and the toe signs were negative. He was thought to have a left parietal thrombosis. Within the next six hours he had 10 grand mal convulsions and was semi-comatose.

The following day he was confused, nonresponsive and did not recognize his relatives. He repeated words or phrases without comprehension. This continued for about four weeks with gradual improvement but it required seven months to fully regain his reading ability. During this time he had two grand mal convulsions in spite of anticonvulsant therapy. Since his last seizure, in April 1957, he has been working periodically and enjoys his work. The electroencephalogram was normal.

Seventeen months after his second lobotomy he was reading with correct understanding of the content. He has had no convulsions for one year and has only minimal compulsive rituals without anxiety.

Other than this, there have been no patients who developed convulsions.

Comment

The Grantham procedure of ventromedial quadrant electrocoagulation has been shown by many workers to have beneficial clinical results.^{3,4,5,6} All agree that it has distinctive advantages over

previous types of lobotomies. It is a simple technic that may be repeated easily if necessary. In practically all cases there have been no postoperative epileptic seizures reported. The hospital stay is short and special nursing is not required. The patient is often able to return to work in a month and may need little or no further treatment. In practically all patients there is a lack of personality disturbance following the procedure. In our series if any did occur it was minimal. These factors must be considered in comparison to many years of expensive psychotherapeutic treatment and medication.

Fulton is of the opinion that the Grantham procedure constitutes the greatest advance in lobotomy technic to date. Ayd⁶ concurred, stating that it represented a tremendous advance in the field of psychosurgery. It is, however, only one facet of the total therapeutic program and should be followed by psychotherapy and other rehabilitative measures. In seven cases of this series additional electroshock therapy was required.

One of the criteria for selecting patients should be that of an individual who has exhibited a stable pre-morbid personality. At the time of operation his personality should be intact or fairly so. Thus, the Grantham procedure proves out better in neuroses or non-deteriorated psychoses. The 13 cases in this series in which good results were attained were those of obsessive-compulsive neuroses, phobic reactions, nondeteriorated schizophrenias and manic-depressive psychoses. Solomon and Greenblatt with their bimedial operation, similar to the Grantham technic, showed by means of the Mecholy[®] test of Funkenstein that this was the most physiologically correct type of operation. The changes in these tests postoperatively were essentially in a favorable direction.

Philosophical Considerations

The question of when to perform a lobotomy has frequently arisen. It has been said⁵ that when one gives up anxiety and depression one also relinquishes in some measure the emotional charges necessary to experience exaltation and other joys of living, that no person of creative ability has been restored to normal after lobotomy, that all must pay a price for release from anxiety. The question was raised as to when we have the right to advise a fellow human being to give up the struggle with anxiety and retreat to a lower emotional level.

It seems to me that we are not asking them to give up the struggle with anxiety or retreat to a lower emotional level but that by this type of specific procedure the *overload* of affective forces is diminished to the point where it approaches the

normal, thus allowing the ego mechanisms of the personality to cope with them more effectively and not be involved in a constant anxious struggle.

So far those cases subjected to the Grantham procedure have been patients⁶ who for many years, even while carrying on their jobs, have suffered from persistent anxiety or depression, agonizing obsessions, tormenting phobias, recurrent doubts or irresistible compulsions or those who have been refractory to all types of therapy. In the future this procedure might well be used earlier in those types which we are now trying to determine respond most favorably. Why should a patient be allowed to experience a seriously restricted life, ridden with anxiety for fifteen years because of agoraphobia, when we know that a Grantham lobotomy may well restore him to normality?

At the present time the Grantham technic has proved to be the procedure of choice when a lobotomy is indicated.

The selection of each case for a Grantham lobotomy must be evaluated in terms of the individual's own needs and should not be considered as a treatment of last resort. Anxiety in all its manifestations is the primary consideration for the use of this procedure.

Summary

(1) A series of chronic psychotics and psychoneurotics refractory to all other forms of treatment were subjected to a Grantham lobotomy. Four had a second lobotomy.

(2) Thirteen of the 24 patients responded with excellent results (55 per cent). Four more (17 per cent) were greatly improved.

(3) Complications may occur and be quite serious. One such case is reported.

(4) The patients most responsive to this procedure were those with obsessive-compulsive neuroses, phobic reactions, paranoid schizophrenias and manic-depressive psychoses in that order.

(5) In this series the involutional psychoses in elderly people did not do well and one patient died. Advanced cerebrovascular disease seems to present a contraindication.

(6) Anxiety, in all its various manifestations, should be the main criterion for determining the selection of patients.

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Dissecting Aneurysm of the Aorta

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A DISSECTING aneurysm of the aorta represents one of the most terrifying catastrophes to which man is heir. By far the most common symptom is chest pain, often described by the patient as tearing in character. The pain may radiate into the abdomen and lower extremities like an electric shock, travelling with equally great rapidity and intensity. Since the dissection usually starts in an area of intimal rupture in the ascending arch of the aorta it may extend a variable length and produce a wide variety of findings. Aside from pericarditis and pleural effusion, most of the symptomatology is due to ischemia of a major aortic branch. It is easily understood, therefore, how the findings may be so diffuse and widely varied.

The basic histologic abnormality in a dissecting aortic aneurysm is cystic necrosis of the media. When a small area of intimal rupture allows entry of blood into it, the inexorable pulsatile systolic thrust of the blood column dissects along the diseased media in an almost unopposed fashion. Thus a double barrel is formed. (Fig. 1)

It is clearly seen then that this type of "aneurysm" is in no manner associated with the more frequent and better known arteriosclerotic aneurysm.

Cystic necrosis of the media largely occurs for no particular reason and has no clearly understood pathogenesis. There are however certain disease states which seem to be associated with this lesion in an incidence too high to be coincidental. Thus, Marfan's Syndrome, coarctation of the aorta, pregnancy and granulomatous giant cell aortitis are thought in some way to be related to this peculiar change in the media of the aorta.

Prior to the past few years this lesion represented a medical curiosity about which one could do little other than treat symptomatically. Forty to fifty per cent of the patients die in the first 24 hours.¹ Death in these instances, results from perforation of the adventitia into the free pericardial, pleural or abdominal cavities, or obstruction of any major aortic branch. Of those patients surviving 24 hours, most are dead by the end of the first week (75-90 per cent).

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A few patients have survived at least for a time on conservative management. In these the dissection has ruptured back in the aorta forming a double barreled vessel or the aneurysm has filled with clot and healing and obliteration of the channel has occurred.²

A bold surgical attack has been made on this

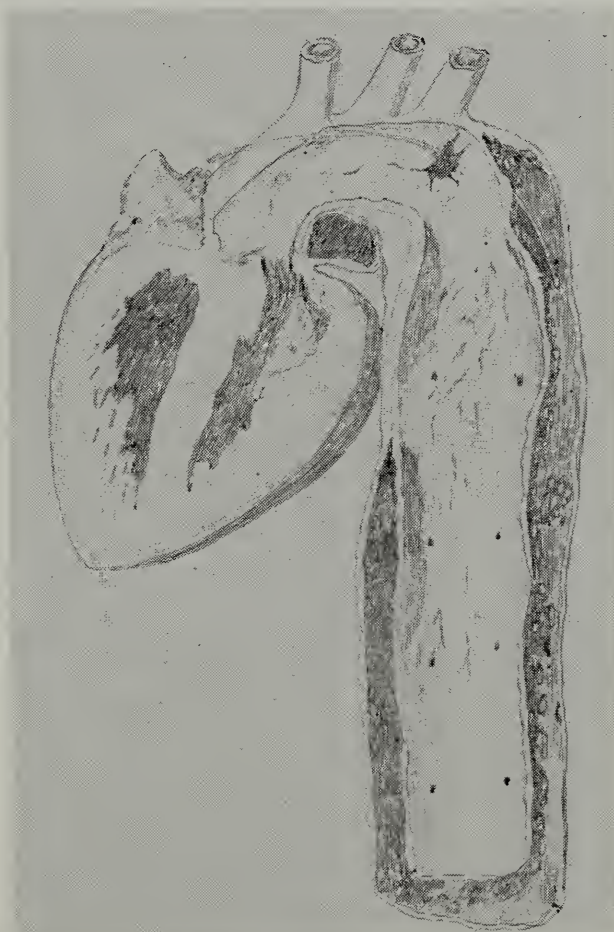


FIG. 1. Specimen showing intimal rupture and dissection.

problem by several pioneers.^{3, 4, 5} It remained however for DeBakey in May of 1954 to demonstrate the feasibility of a surgical approach to this problem. He successfully operated upon a

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58 year old man with a dissecting aneurysm⁶ by the technique illustrated in figures 2 and 3. This method necessitates the induction of a hypothermic state to allow cross clamping of the aorta for the time necessary to effect repair. The aorta is transected just distal to the left subclavian artery and the hematoma aspirated from the proximal and distal portion of the vessel. The intima and adventitia of the proximal end are sutured together with a continuous stitch leaving a V shaped section of intima open to allow the blood from the "dissected" area to be discharged into the distal segment. The layers of the distal portion of the aorta are sutured together and then aortic continuity is re-established by direct end to end anastomosis.

Case Report

The patient*, a 62 year old white man, was admitted to Huron Road Hospital on January 7, 1958, with a chief complaint of severe squeezing pain in the upper abdomen and lower chest. This pain was worse on lying down. He had been hypertensive for several years. The patient was bathed in perspiration and complained bitterly of pain. There was no respiratory distress, cyanosis or unusual pulsations. The heart sounds were faint but no murmurs were audible. The pulse rate was 76, rhythm normal sinus and blood pressure 198/130. The peripheral pulses were all palpable. The chest was

*Referred and studied by Drs. O. L. Hawk and E. Goyette.

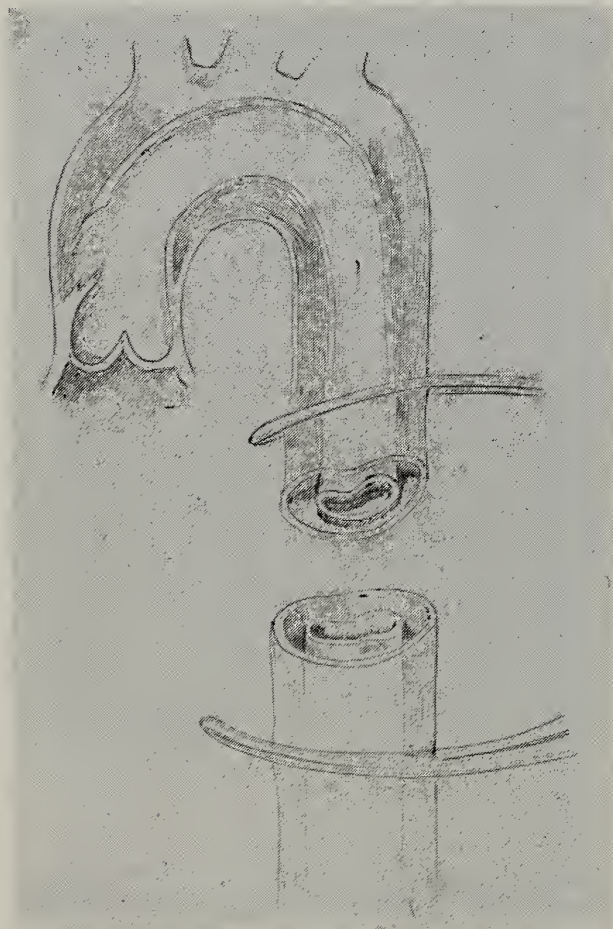


FIG. 2. Technique of surgical correction.

clear. The abdomen was held taut but no masses could be palpated. Peristalsis was normal.

Laboratory data at this time were as follows: white blood cell count 14,500 with a left shift. Serum amylase 32 units. Urinalysis: albumin 2 plus, sugar 2 plus, negative for red blood cells and bacteria. The electrocardiogram was normal. A chest film disclosed widening of the ascending aorta. A barium swallow disclosed the stomach to be within the abdominal cavity.

He was given morphine gr. 1/8 by his company physician immediately after the onset of pain. On entrance to the hospital he was given another 1/8 gr. of morphine. An hour later gr. 1/6 of morphine failed to relieve his pain.

Three hours after admission he had severe pain localized to the left precordium. Deep breathing was intolerable. A few rales had appeared at the bases. On January 9, 1958, a pericardial friction rub was heard by one examiner.

Laboratory data January 9, 1958: Transaminase 6 units, sedimentation rate 31. Urine, negative. Hemoglobin 15.6 grams. White blood cell count 20,500; polymorphonuclear leukocytes 82. Blood urea nitrogen 22 mg. per 100 ml. C reactive protein 4 plus.

A chest film disclosed effusion at the left base. Thoracentesis yielded 650 cc. serosanguineous fluid.

On January 13, 1958, he was taken to the operating room with a diagnosis of dissecting aneurysm of the aorta. Hypothermia was induced under general anesthesia and a temperature of 84°F. was reached. Then a left postero lateral subscapular incision was made.

Upon entering the left pleural space a large dissecting aneurysm of the entire thoracic aorta was noted. The aorta was adherent to the esophagus. The aorta was isolated, several pairs of intercostal vessels were isolated, tied and transected. Then by following the technique as illustrated in figures 2 and 3, the dissection was repaired.

The postoperative course was complicated only by some superficial burns received on the lower extremities in the rewarming period immediately following completion of surgery. He was discharged in good condition on February 4, 1958.

Summary and Conclusions

A brief review of the problem of dissecting aneurysm of the aorta has been presented. The urgency of surgical intervention is obvious since the outcome from symptomatic treatment is almost uniformly fatal. Although formerly the lesion was rarely diagnosed pre-mortem, a high index of suspicion will undoubtedly result in more frequent valid clinical appraisals.

Myocardial infarction represents the most difficult differential since the clinical findings in both may be similar. Unless the dissection occurs proximally to include the coronary arteries and thereby produces myocardial ischemia or infarction, the electrocardiograph is of great importance in differentiating the two conditions. The usual patient with dissecting aneurysm does not have an ischemic pattern.

Although in many instances there is not sufficient time for elaborate clinical studies, an angiogram may be diagnostic. Here the double barreled aorta may be demonstrated with a central dense column in juxtaposition to a less dense

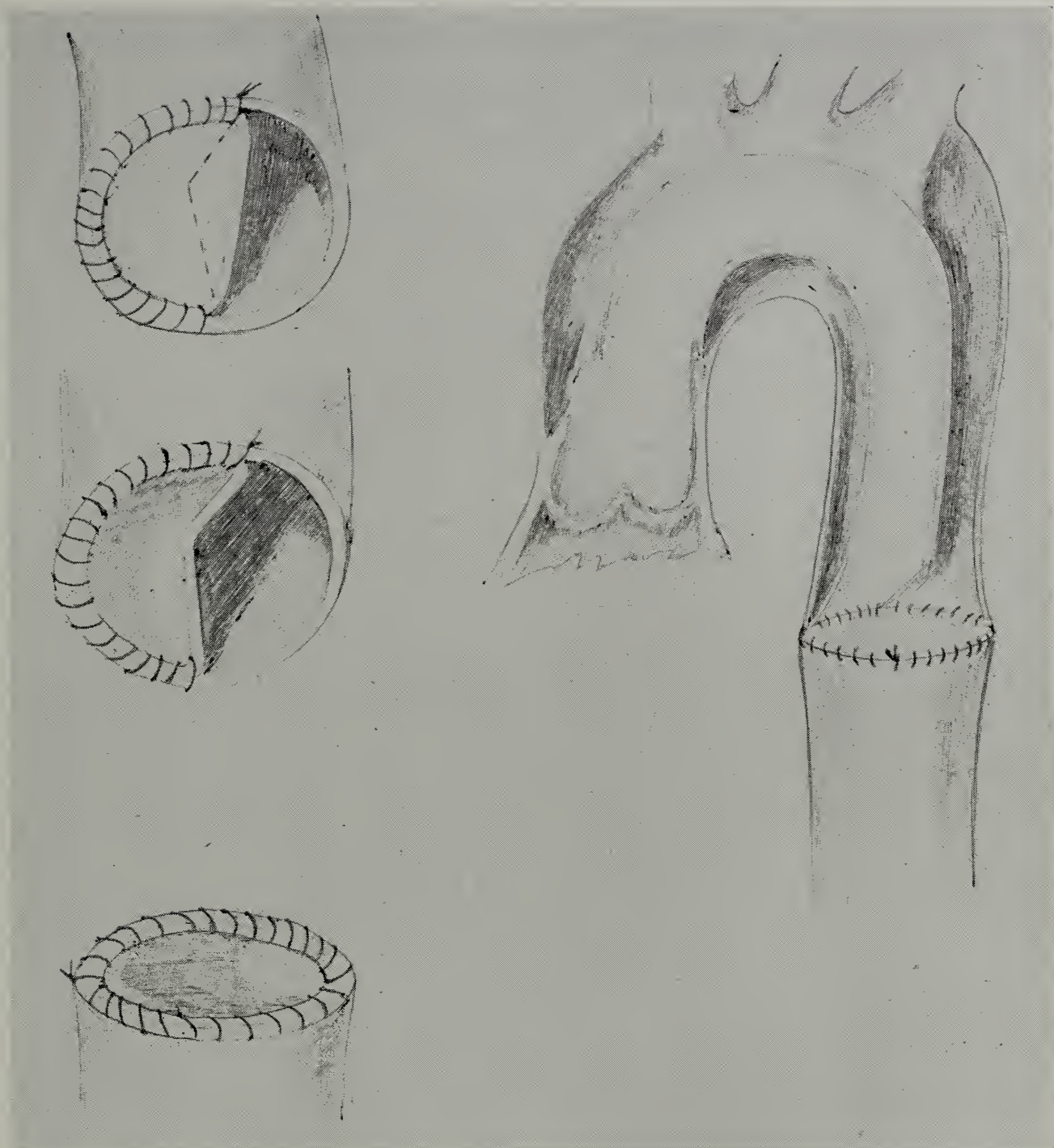


FIG. 3. Technique of surgical correction (Continued).

column; the latter representing the area of dissection.

A feasible surgical attack has been evolved and it is our feeling that all patients with this lesion should be given the opportunity for surgical correction if they are considered able to survive the necessary preparation for surgery, i. e. anesthesia and induction of hypothermia.

The patient described in the foregoing is alive and well. His hypertension is controlled by medication and he is asymptomatic. He is working 40 hours weekly in his former occupation.

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Clinical Experiences with Tetracycline Phosphate Complex, Novobiocin Capsules (Panalba®) For the Therapy of Acne

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Introduction—Acne and Maturity

IT has been conservatively estimated that at least 50 per cent of all persons between the ages of 14 and 24 years at some time will be afflicted with acne. In considering the etiology of the disease, much work has been done regarding the anatomy, pathology, chemistry, physiology, and psychology involved. Therapy seeking to coordinate these findings with empirical therapeutics based upon long experience runs the alphabetical gamut from the "A" of vitamin A through the "XYZ" of x-ray, youth counseling, and zinc oxide. None has done much more than to minimize the disorder until the patient reaches a more mature stature. The attainment of the maturity of the early third decade of life usually produces remarkable changes for the better.

Bacterial infection, a frequent and serious complication of the condition, seems to succumb to changes in the patient's immunological processes. Adults, even those with oily skins, infrequently suffer from pyogenic dermatoses, even in the former acne areas. Of course, one does see such infectious disorders, but not with the great frequency with which they appear in the acne areas.

Psychic stimuli, that formerly produced adverse effects in the acne patient, show a change in pattern in the adult. Here they are more likely to be associated with such dermatological states as urticaria, neurotic excoriations, facticiae, lichen simplex, and the group commonly termed "neurodermatitis." Menstruation, which commonly produces flares in the teen-age acne patient, does not seem to do so in the more mature woman. The dietary errors of the teen-ager, supposedly so important in the clinical outlook for the acne patient, may be continued, or may be augmented by alcohol, tea, coffee, rich foods, etc., yet the acne improves. Adults use more cosmetics, have less regular sleeping and eating habits, are more subject to exposure by occupational irritants, travel more, et cetera, yet the acne improves with maturity. It seems logical, therefore, to assume that if

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we were able to hasten maturity, we could thereby greatly improve our management of acne.

Antibiotics, Maturity and Acne

Clinicians have been using the antibiotics as an adjunctive in the therapy of acne for almost as long as they have been commercially available. In most instances they have been utilized for their value in reducing the bacterial infection present in many patients. One must not, however, lose sight of the fact that the antibiotics possess another inherent quality. They are very capable of hastening maturity.

From data supplied by our local Farm Bureau, it is noted that adding the so-called "wide-spectrum" antibiotics to the feed of young swine, sheep, beef cattle, and poultry stimulates growth of the animals to reach market size and quality, in definitely shorter time than had they not been so fed. Adding antibiotics to the feed after a certain length of time does not cause the animal to grow to any larger size than is usual for the type of animal, or to show any other abnormality. It goes without saying that infectious diseases are also minimized by the use of antibiotic food supplement. The advantages to the agriculturist in thus accelerating growth are obvious.

Horticulturists, rosarians for example, also use this type of feeding. The plants bloom sooner, show better coloring, have larger flowers, and are more hardy. The same thing is done in orchards and on grain farms with the same sort of results. While there may well be some serious objections to doing so, it is interesting to speculate upon the possible results of so supplementing the food for infants and younger children. At any rate, it is rational to feel that this growth stimulat-

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(Panalba for this study supplied by The Upjohn Co., Kalamazoo, Michigan.)

ing factor possessed by the antibiotics might well be of value in the treatment of acne.

We are well aware of the objections that might be raised to their prolonged use. Sensitization, moniliasis, tolerance, changes in the bacterial flora to produce resistant strains or, mutations, etc., are well recognized. However, these do not seem to be very common in animal feeding or horticulture, and perhaps could be kept to a minimum in our use by changing brands, intermittent rest periods, and other practical measures. A tremendous amount of penicillin is used today, often without justification, yet not too many of the foregoing complications are seen. Certainly, if the penicillin were more judiciously utilized, many of the reactions we do see would be eliminated.

With due consideration of these factors, this study was done to clinically evaluate the usefulness of capsules containing tetracycline phosphate complex 250 mg. plus novobiocin 125 mg. as a therapeutic agent for acne.

Methods and Materials

Two groups of patients from our private practice were carefully selected for this study. All patients were white— simply because no Negroes qualified for this study.

The first group of 16 patients consisted of patients in whom the usual therapeutic measures being used for observable lengths of time did not appear to be giving adequate results. These therapeutic measures were continued unchanged from what they had been, and then Panalba® capsules were added to the regimen according to the schedule to be outlined later.

The second group of 26 patients was composed of new cases. Thus a total of 42 cases was studied. None of the patients of the second group had ever had prior treatment from a physician.

Preliminary estimation of the severity of each case was established upon the basis of several criteria. These included the extent, density of involvement in active sites, known duration, pustule or cyst formation, presence of other dermatoses (seborrhea, eczema, etc.) evidences of systemic disease, etc. We also took into consideration such extraneous factors as occupation (gas station workers, policemen, machine shop workers, etc.), family cooperation, and the apparent intelligence of the patient.

Our dosage schedule and technique was at some variance from that of James¹ who used the same materials, both systemically and topically, in conjunction with other therapeutic modalities, and who was primarily interested in their use in the pustular forms of acne. While many of our patients showed pustular formation to variable de-

grees, our main interest was in those cases in which the predominant features were the inflammatory papules, comedones, and erythema basic to all acne. For these reasons our results must be interpreted differently than his. Our evaluation of the results was critical, and was based more upon the changes of these true acne lesions than upon the more evident control of bacterial activity.

Dosage and Pre-Treatment Evaluation

Our basic dosage schedule used for both groups of patients was as follows: *First Week* 1 capsule three times daily, *Next Two Weeks* 1 capsule twice a day, *Next One to Three Weeks* 1 capsule daily. Patients in Group II were instructed to maintain good hygiene and to avoid all trauma or manipulation of the skin. The only restrictions of the diet were the prohibition of chocolate, nuts, salt water fish, and seafood. No other forms of therapy or other instructions of any kind were given to the patient. In some instances the dosage schedule was varied to a minor degree for certain individual patients.

All patients were carefully observed at least once weekly, and notation made of their progress. Whenever possible we attempted to see the patient again in about a month after the Panalba therapy was stopped, in order to observe any recurrences. In some of these instances another, but shorter, course of Panalba was resumed. These repeat courses were not considered as part of the observation.

Group I (those receiving other medication, etc.) was composed of nine males and seven females whose ages ranged from 14 to 36 years with an average of 19 years. Of the 16 patients in this group, six were ranked as "severe" and 10 as "moderate" before treatment. The average length of time per patient's treatment period was 36 days with the average dosage being 59 capsules.

Group II (those patients receiving no forms of therapy except the Panalba) consisted of 15 males and 11 females between the ages of 12 and 32 years, with an average age of 17 years. Pretreatment evaluation as to severity classified 18 as "severe" and eight as "moderate." (No "mild" cases were included in this study.) The Group II patients averaged 29 days of treatment, and received an average of 51 capsules during this time. Actually some 50-odd patients were begun, but some had to be disqualified for various reasons, and some failed to keep on with the study. At this writing we have some newer cases under treatment, but the time is too short for proper evaluation.

Results

The patients were observed at approximately weekly intervals, and careful study was made of the

changes, reactions, complaints of the patient, etc. In the evaluation of results we attempted to be critical and accurate. We felt, however, that we were justified in rating results as "good" or "fair," even though there were still active acne lesions present at the end of the observation period. We did not begin this study with the idea that this medicament was to furnish the physician with a fast, infallible, inexpensive, and painless cure-all. We felt that "good" results were represented by really definite improvement in the clinical picture, to the extent that the majority of the lesions showed only modest activity at the end of the given time, that no new lesions were appearing in the already involved sites or in other sites, and that results were at least as good as, or better than, those usually expected from good orthodox dermatological measures. The other ratings of the results were also made on this basis.

In Group I, the results in six patients (37 per cent) could be rated as "good," in seven (44 per cent) as "fair" and in three (19 per cent) as "poor." Of Group II, 15 (57 per cent) had "good" results, 10 (48 per cent) "fair," and one (5 per cent) "poor." The grand total revealed 50 per cent "good," 40 per cent "fair," and 10 per cent "poor" results.

In Group I, one patient was five months pregnant, and had failed to complete her course, but showed good response in 24 days. One patient, a policeman, developed pruritis ani early in the course, but this subsided spontaneously as the dosage decreased. A total of five patients complained of moderate diarrhea at the onset of treatment, but in all cases this subsided without treatment as the dosages were reduced. One patient in Group II blamed the Panalba for her insomnia, which she suffered for the first two weeks. This also disappeared without treatment. No other reactions and no evidences of sensitization were noted.

Our most resistant cases were in Group I, and represented relatively older individuals, in whom all forms of local therapy, radiation, vitamin A, the use of other antibiotics, and similar procedures had failed. In these cases the addition of Panalba did not seem to help matters too much. Perhaps a longer trial period would have been advantageous, or perhaps the processes of acne had been so well founded in the tissues, that the antibiotic influences were not strong enough to reverse them with the dosages employed during this time period.

Discussion

This study was instigated by a desire to correlate the impressive benefits bestowed upon acne

by maturity with the less well-known growth stimulating properties of the antibiotics. Because of practical limitations imposed by the forces of time, available facilities, economic factors, and the real or academic objections to prolonged administration of antibiotics, much that would have been desirable in the project was left undone. One might well have done complete studies of the bacteriology involved, serial biopsies of the healing lesions, endocrine studies, chemical analyses of the changes in the tissues and sebaceous material, etc., and thus have a far more complete picture to present. Perhaps others, more fortunately situated, may do so later. Results of this project, while certainly not conclusive or astounding, do seem to point the way towards better management of acne.

Pharmacodynamics of Antibiotics

The attempts to translate the action of the antibiotics in the fields of animal husbandry and horticulture into the clinical application for acne are surely difficult. For example, the suggested supplement of antibiotics to feed for young cattle is 150 Gm. to each ton of feed. The suggested feeding is 1 pound per head per day. This would mean only .075 Gm. per day for each animal. One immediately wonders how this trivial amount can be of value when it is compared to the usual dosages of .750 to 1.500 Gm. daily utilized in treating human diseases. This is especially impressive when one realizes that the cattle will attain weights of something like 1000 pounds and the human being about 160 pounds. In animals these apparently minute dosages seem to be amply bactericidal, and also demonstrate their definite growth stimulating ability. However, one should be mindful of the fact that these trifling dosages are fed daily over most of the usual growing ages of the animal, and this is a matter of a limited number of months. To put this into proper relationship to the human animal we would need to feed very small traces for a number of years.

Jorgenson² also comments upon the very small traces used in rose growing. He states: "You will observe that the dose is really trace in size. One to four parts per million—one to four milligrams to the litre or quart. It is added to the foliar plant food solution, and thus it is applied to the leaves." Perhaps the results should not be thought of in terms of daily dosages, but in terms of the total amounts utilized over the time span in which they are administered. Carefully done studies of tissue storage and excretion, and the metabolism of the antibiotics thus administered might well throw more light on the processes

involved. Jorgenson,² in commenting upon these possible processes, says:

"Just how this is done has not been ascertained. The thought is that the antibiotic is broken down into degradation products, and that they may in some manner inhibit or neutralize growth restraining factors. In view of the homeopathic dilution, we cannot ascribe any of the effect to bactericidal activities." This viewpoint certainly has value, but we again emphasize the need for considering the prolonged time element, as well as the small individual doses.

Another interesting factor to be considered is that for optimum results both in animal husbandry and horticulture the antibiotics must be combined with well balanced food materials. Simply adding antibiotics to a defective diet does not consistently show the beneficial activities previously noted. It may well be that the antibiotics in some way act as catalysts to improve the utilization of the food, and thus cause the increased rate of growth.

It is unfortunate that in this study we could not have used a schedule of very small daily doses over a prolonged length of time. We are convinced, particularly in considering the results in Group II, that the Panalba has definite merit in treating acne, and that the results were not those simply due to its bactericidal activity. Even allowing for the influences of bacterial allergy or more remote toxic effects, we still noted marked improvement in many lesions that did not show any evidence of infection, either individually or in the general area. Any bacterial activity, due to organisms sensitive to the Panalba, should have shown its most marked improvement earlier in the course of treatment while the dosages were at the maximum, yet often the improvement showed a slow onset with later steady gains even while the daily dosage was only one capsule.

Economic Considerations

From the practical viewpoint this project may be of mild interest. None of the antibiotics of this type are low-priced from the consumer's viewpoint. Few patients would be willing to use these products for prolonged periods of time for a disorder which, to their minds, is neither dramatic nor dangerous. This project demonstrates that, while for the first week or two the outlay might be somewhat of an item, the maintenance cost drops to a more modest amount as the treatment period is lengthened. Perhaps it is not necessary to start with even the fairly reasonable number of capsules that were used, and thus the cost could be further reduced. Another item to consider is that the less time and effort it takes the patient to take his medicine, the better co-

operation may be expected. A single capsule daily should prove easy for the patient to remember, and to purchase.

Summary

1. The established practice of supplementing the feeds of young domestic animals and of plants in order to hasten growth was suggested as a basis for accelerating maturity in the acne patient, and thereby improving the management of this disorder. The dosages translated into use for growing infants and children would be decidedly larger since human growth periods are much longer. Serious objections to such administration might be well founded.

2. Two groups of acne patients were administered capsules containing tetracycline phosphate complex 250 mg. and novobiacin 150 mg. (Panalba) according to a predetermined dosage schedule. Group I was composed of 16 patients in whom conventional dermatological therapy had not been satisfactory. The antibiotic capsules were administered, and the former therapy was allowed to remain unchanged. Group II was composed of 26 new patients who had never had any medical care by a physician. Other than simple instructions as to hygiene and diet, no other form of therapy except the antibiotics was utilized. Evaluation of the pre-treatment status was graded as to being either "severe" or "moderate."

3. Post-treatment status of both Group I and Group II was critically evaluated. Results were graded "good," "fair," or "poor," and these have been enumerated. Side effects and reactions were also noted.

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Fate of Aortic Implants

Fresh abdominal aortic homografts were implanted into the abdominal aorta of 14 dogs subjected to a chronic cholesterol-thiouracil or cholesterol-radioactive iodine regimen. The fate of these grafts was studied by histological and biochemical methods.

Atheromatous lesions were present in variable degrees throughout the arterial system in all animals. The thoracic aorta was free of atherosclerosis in all but three cases. The host abdominal aorta was involved in 12 of 14 cases. The graft was always the site of atheromatous degenerative changes and, as a rule, appeared to be more involved than the host abdominal aorta.

Fresh abdominal aortic homografts showed marked susceptibility to experimental atherosclerosis, in contrast to fresh thoracic implants, which, as reported previously, remain largely refractory. *A. M. A. Arch. Surgery*, 78:239, February, 1959.

Office Photography for the Practitioner

EUGENE M. FUSCO, M.D.

VISUAL records add greatly to the efficiency and enjoyment of office practice. A few years ago the doctor had to be a hobbyist to attempt photographic recordings. Even then an inexhaustible fund of enthusiasm was required. Equipment was bulky and expensive, static in design and maneuverability, and limited essentially to black and white film.

With the surge of 35 mm. photography all of these problems have been solved. (Fig. 1)

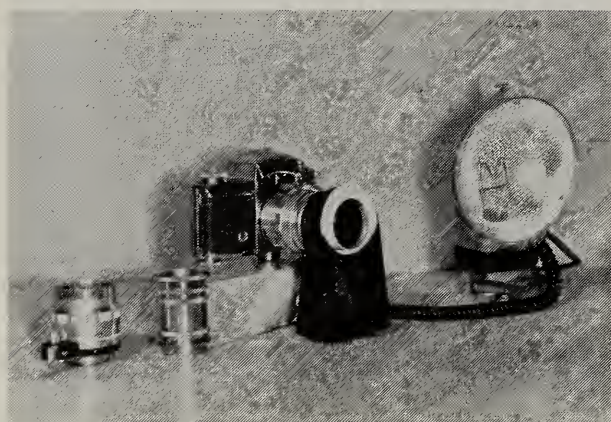


FIG. 1. 35 mm. equipment for office photography reading from left to right: automatic 50 mm. lens, extension tubes, 35 mm. camera with a 35 mm. wide-angle lens and a ring light, and an electronic flash tube.

No knowledge of photography is required to turn out professional records and best of all the system can be managed by office personnel.

The Ideal Camera

The single lens reflex is the ideal camera for clinical photography. It eliminates parallax. In the average camera the viewfinder is separate from the lens. The image defined in the viewfinder does not coincide with the image on the film. In the single lens reflex viewing is done through the taking lens and the image can be sharply centered. Since clinical photography is essentially closeup or macro-photography parallax is a vital consideration.

Another advantage of the single lens reflex is the eyelevel finder. Since the average doctor is in the middle age group this assumes paramount importance. With the eyelevel finder a bright image is secured and focusing is easy even in a dimly lighted room. Many eyelevel finders incorporate a fresnel type range-finder

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which is a superlative addition for dim light focusing.

Interchangeability of the lenses is a feature of the single lens reflex. The normal or taking lens of the 35 mm. camera is the 50 mm. or two inch lens. That is, the distance from the lens to the film is 50 mm. Other lenses available for the single lens reflex are the 35 mm. or wide-angle and the 90 mm. which is a moderate telephoto.

The Ideal Lens

The wide-angle lens is rapidly becoming the standard lens for the 35 mm. camera. The wide-angle lens has the unique ability to increase the field of view by about 15 degrees while increasing the depth of field. Depth of field refers to the distance in front of the subject and behind the subject which remains in focus at a given exposure. A good wide-angle lens can be focused from eight inches to infinity. This obviates the need of attachments for the average closeup. The only fault of the wide-angle lens is moderate distortion due to bending the light rays.

A classification of picture taking will be helpful to office personnel. This includes normal pictures, medium closeups, closeups, macro-closeups, and micro-closeups.

Normal pictures are taken with a 50 mm. lens at a distance of four feet to infinity. Medium closeups are taken with a 50 mm. lens at a distance of two to four feet. No accessories are needed at two feet with the 50 mm. lens. Closeups are pictures taken at distances from ten inches to two feet. Closeups can be taken by a good wide-angle lens without accessories. Macro-closeups are taken at distances under 10 inches and provide enlargements up to 25 diameters. Micro-closeups extend the range from 25 diameters to many thousand diameters.

Macro-photography is generally defined as photography at distances less than 10 inches. For macro-photography some accessory will be necessary. This can be a portrait lens, extension tubes,

or bellows attachment. The taking lens of your camera is a precise optical instrument and cannot be improved by an inexpensive portrait lens made of inferior glass.

Camera Accessories

Extension tubes provide rigidity and standardization since exposures are made at a fixed distance and focusing is not required. They have the disadvantages of shallow depth of field and the need for two to four times as much light as a photograph taken without tubes. For the clinician extension tubes will be preferable to the bellows attachment.

Filters have little place in clinical photography. They are effective in black and white photography but are unreliable in color work.

Color film is admirably suited to clinical use. It is inexpensive and relatively stable with proper care. It can be mounted as a slide or returned as a color print. At the present time color prints lack the brilliance and quality of slides and most clinicians prefer slides for a permanent collection. The average slide is two inches by two inches, is flexible, and requires little space for storage. Slides can be studied by hand viewer or projected on any size screen. Good color photography requires laboratory processing and is not suitable for home processing.

The light source is a major concern in office photography. It is wise to choose a light source whose color temperature can be calibrated accurately and will be standard. Color temperature is measured in degrees Kelvin after Lord Kelvin the English physicist. Lord Kelvin observed that color changes occurred when the temperature of a metal was increased. At 6000 degrees the color was white. As a result of Lord Kelvin's observation day-light color film has been standardized at 6400 degrees Kelvin while tungsten type color film has been standardized at 3200 to 3400 degrees Kelvin.

Daylight is unsuitable for clinical photography since it changes in intensity and quality from hour to hour. Ordinary house lights and spotlights have uncertain Kelvin potentialities. This leaves a choice of photofloods, flashlamps, or speedlights.

Photofloods are hot and disturbing to adults and children and are unsuitable for clinical work. The flashlamp is a menace to both patient and clinician. For clinical use the speedlight or electronic flash is the perfect light source.

The speedlight is an electronic flash unit whose color temperature is approximately 6500 degrees Kelvin. This makes it a good match for daylight color film. The cost per flash is a fraction of that for the flashlamp though the initial outlay is

greater. Its other attributes are coolness, mobility, precision, lack of weight, and ability to stop any kind of motion without a tripod. Its weight is generally under 2 pounds. No batteries are required. The speedlight will last the amateur photographer a lifetime.

A tripod or other fixed source will not be necessary with speedlighting since the average flash lasts about 1/1000 of a second.

Background material should provide neutral or contrasting colors with an uncluttered field. Solid green makes an ideal background for skin tones or cavity work. Any dark colored office wall will be adequate and offers the advantage of stability and size.

For specialized photography of the mouth, eyes, ears, vagina, or rectum the ring light is a useful accessory. (Figs. 2 and 3) The ring light fits around the taking lens and throws a crisp shaft of light directly to the subject. It must be remem-



2. FIG. 2. Setup for photography at distances under 10 inches. Camera, extension tubes, 50 mm. lens, and ring light.



FIG. 3. Close-up photography of the mouth, vagina, or rectum. Camera, 50 mm. lens, ring light, and speculum. The speculum can be interchanged with other instruments.

bered that both speedlights and flashlamps are capable of igniting volatile or inflammable gases when sufficiently concentrated.

Some method of marking each picture should be

employed. A small typewritten label with the name and number of the patient can be added to the photographic field though the best practice is to mark the slide after it is returned by the laboratory. Since the slide is only 35 mm. in width anything cluttering the photographic field should be avoided.

Summary

It is the feeling of many that automation in photography has arrived. With automation the visual record will supplement and simplify office records. A review of photographic equipment and methods has been presented with the view of simplifying clinical photography for the busy practitioner.

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Parenteral Iron Therapy for Iron Deficiency

Parenteral iron therapy has been used in 103 patients with evidence of iron deficiency and anemia. The main indications for the use of parenteral iron in this series included disinclination toward oral iron by the patients and failure of oral iron to effect a satisfactory response.

Sixty-nine (about 70 per cent) of the patients had a satisfactory response to therapy as indicated by an average rise in hemoglobin concentration of 0.275 Gm. per 100 cc. of blood per day. Thirty-one of the patients (about 30 per cent) had a poor response as indicated by a rise in hemoglobin of less than 0.1 Gm. per 100 cc. of blood per day. In 26 of this nonresponsive group overt complications appeared to prevent the proper response. These included infection, uremia, carcinoma, and continued blood loss.

It may be possible to overcome the adverse influence of continued blood loss on the response to therapy by increasing the dose of parenteral iron over the 2 to 5 week period of therapy. On occasions a satisfactory response was obtained only after definitive management of the lesion responsible for the blood loss had been instituted.

Complications were not a major feature of this experience. In view of this and the reasonably precise nature of the therapy and the satisfactory response at all ages, it may be of value to liberalize the indication for parenteral iron therapy in iron deficiency as indications are now considered in the literature.—R. K. Bass, M. D., E. R. Halden, M. D., and E. E. Muirhead, M. D., Dallas: *Texas State J. Med.*, 55:22, January, 1959.

Staphylococcal Pneumonia Demands Vigorous Antibiotic Treatment

Staphylococcal pneumonia, particularly in a hospital patient, represents a grave threat to life, and this threat is present now in all hospitals. It is highly important to keep this possibility in mind, and the appearance of clinical pneumonia in a hospital patient, especially in those already on steroids or antibiotics, should be regarded as a staphylococcal pneumonia until proved otherwise. As staphylococcal pneumonia is a necrotizing process, causing multiple small abscesses, treatment during the first few hours is mandatory. During the first few hours of such a pneumonia, it is impossible to distinguish it clinically from any more benign bacterial pneumonia, and if treatment is to be successful vigorous therapy during those first few hours is essential.

As soon as a clinical diagnosis of pneumonia is made, sputum and sensitivity studies should be started; then energetic treatment of this pneumonia with antistaphylococcal drugs should be undertaken during the time needed to confirm the diagnosis. As certain strains of staphylococci tend to be constant and predominant in any one hospital, the choice of antibiotics might be determined by data already collected on previous cases by the hospital laboratory. Vigorous treatment by a battery of such antibiotics to which other staphylococcal cultures have been sensitive will not endanger the patient if the diagnosis is not confirmed. If confirmed, such therapy may mean the difference between a normal living patient, a permanent respiratory cripple, or a fatality.—W. T. Couter, M. D., Decatur, Ill.: *Illinois M. J.*, 115:57, February, 1959.

Blood Pressure After 65

Blood pressure does not rise progressively after age 65 as it does up to that age. In men, systolic pressure remains relatively constant throughout the remainder of life. In women, diastolic pressure remains relatively constant but systolic pressure rises somewhat reaching a peak in the 70-74 age bracket. Then it declines steadily. After 90, male and female systolic pressures approach equality.

These conclusions are based on a study of blood pressure of 5757 apparently healthy white persons of both sexes aged 65 to 106. They were not institutionalized and represented a socioeconomic cross section. Data were collected from questionnaires filled out by more than 5000 physicians sampled across the nation on the basis of distribution of persons more than 65 years old.—A. M. Master et al., New York: *Geriatrics* 13/12:795-800; abstr. by *World-Wide Abstr.*, 2/3: 10, March, 1959.

Acute, Fulminating Streptococcus Viridans Tonsillo-Pharyngitis Treated with Hormone-Antibiotic Combination—(A Case Report)

EFREN C. NAGUIT, M.D., and THEODORE TETRAULT, M.D.

IT has been well established that ACTH and cortisone have a profound anti-inflammatory effect on human beings and experimental animals. The exact mechanism of such an effect is still unknown but the consensus of opinion points to a direct effect of the steroids on the involved tissues, resulting in the diminution of vascular permeability, exudation and migration of inflammatory cells. This hormone-induced inhibition of localizing tissue reaction results in the prevention of fibrous and degenerative changes; subsequently widespread and overwhelming dissemination of the infectious process occurs. This does not, as a rule, happen if the hormones are administered along or in combination with massive doses of the proper antibiotics.

Case Report

A 46 year old married, white woman was admitted to The Barberton Citizens Hospital because of hyperpyrexia, disorientation and shock. The patient was seen at home the day previous by the family physician and was diagnosed as a case of acute exudative tonsillitis, right. She was given Combiotic®, Cyclamycin® and symptomatic treatment. Six hours later, the high temperature persisted and signs of disorientation and mental confusion appeared. Her past history was essentially noncontributory.

On the day of admission, the patient was disoriented and combative, acutely ill, with cyanosis of the nail beds. Temperature rectally was 105.8 degrees Fahrenheit. Blood pressure 90/50. Pulse rate was 68 per minute. The skin was dry and hot to touch. There were dark brown, crusty lesions on both lips. Tongue was dry and heavily coated. On the right tonsillar area, a thick, bright yellow exudate, covered the whole tonsil extending to the posterior pharyngeal wall. There were no palpable lymph nodes in the neck. The heart sounds were regular but distant, and the lung fields were clear. Abdomen was negative. Neurological examination revealed sluggish deep tendon reflexes but otherwise it was essentially normal.

Laboratory Findings

A complete blood count on admission showed red blood cells 4,440,000; hemoglobin was 84 per cent; 12.9 grams. The white blood cell count was 14,000 with a differential of 2 myelocytes, 15 stab forms, 40 segmented cells, 39 lymphocytes and 1 monocyte. A lumbar puncture revealed an opening pressure of 120 millimeters of water; the spinal fluid was clear and colorless, with a cell count of 2 lymphocytes. The spinal fluid glucose was 142 mg. per 100 ml., the total protein 35 mg. per 100 ml. with a normal globulin ratio. Heterophile agglutination and Leyton tests for infectious mononucleosis were both negative. Blood culture was negative.

The chest x-ray was essentially normal. Electrocardi-

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ogram showed T wave inversions in the standard leads 2, 3 and precordial leads V4 to V6. Blood urea nitrogen was 21 mg. per 100 ml. A repeat blood count two days after admission showed a red cell count of 3,540,000; hemoglobin 68 per cent, or 10.5 grams. The white cell count was 8,500 with a differential of 3 eosinophils, 1 myelocyte, 1 juvenile, 35 stab forms, 23 segmented cells, 35 lymphocytes and 2 monocytes. A repeat blood urea nitrogen was 35.5 mg. A throat culture revealed streptococcus viridans which was most sensitive to penicillin and erythromycin. Nose culture revealed hemolytic *Staphylococcus aureus*, (coagulase positive), which was sensitive to penicillin and Chloromycetin®. *Corynebacterium diphtheriae* was not seen by smear or culture.

Hospital Course

The patient, on admission, was placed under an oxygen tent and started on an intravenous infusion of Travert® Solution No. 2 with 500 mg. of oxytetracycline added through a venostomy in the right leg. She was also given 250 mg. of tetracycline every six hours and Combiotic 2 cc. every 12 hours. Continuous sponging with alcohol brought the temperature down to 101°F. rectally, only to rise to 106°F in two hours. The patient was also given diphtheria antitoxin 80,000 units initially and repeated in six hours. One-hundred milligrams of hydrocortisone was added to the intravenous infusion after this secondary elevation of temperature. The next day, or 16 hours later, the temperature had dropped to normal. The patient was answering questions coherently, although sluggishly, with occasional episodes of disorientation.

The antibiotics were continued for another five days. The only minor complication was a postvenostomy lymphangitis and phlebitis which was summarily corrected. Patient was discharged on the tenth hospital day as fully recovered.

Discussion

Since the original observation of Hench and associates on the effect of adrenal steroids in rheumatoid arthritis, cortisone and ACTH have been used in a wide variety of infections like pulmonary tuberculosis, tuberculous and meningococcal meningitis, brucellosis, typhoid fever, scrub typhus, Rocky Mountain spotted fever, generalized peri-

tonitis, bacterial pneumonias and tetanus. In all of these cases, the hormones were combined with intensive antibiotic therapy. The most notable findings were rapid disappearance of the elevated temperature in 24 hours or less, quicker symptomatic improvement and a feeling of general well-being. There was no acceleration of the disease process in 300 cases reported by Jahn and associates.

The use of ACTH and cortisone in conjunction with intensive antibiotic therapy in certain fulminating infections have been limited to the following conditions:

(a) In nonsurgical diseases where there is excellent reason to believe that the infection will not respond to antibiotics alone.

(b) In surgical conditions only when definitive measures (surgery) are contemplated for the near future.

(c) Hormone administration should always, in the presence of infection, be administered for the shortest possible time compatible with adequate clinical response. It must always be discontinued first before discontinuance of antibiotic therapy.

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Resection of Colon

Methods of resecting the colon have reached such a state of perfection that when acute obstruction is not present the operation is relatively safe. This has come about slowly over a period of almost a century during which countless thousands of patients have died who could now be saved. Every significant advance was arrived at after years of trial and error or after thorough laboratory and clinical investigation. They have been tried in the fire by hundreds of surgeons, and each of them has proven valuable under some circumstances. It is, therefore, imperative that a competent colon surgeon know how and when to use them all. None of them should be forgotten and none should be abandoned until alternate methods have been proven to be better.

The problem of long standing acute obstruction of the colon has not been solved and probably never will be so our efforts should be directed toward its prevention and early recognition.—James D. Rives, M. D., New Orleans: *Texas State J. Med.*, 55:82, February, 1959.

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEPFEL, M. D.
Columbus, Ohio, Chairman

Following is the summary of a case which was discussed before the Franklin County Pelvic Cancer Delay Committee on January 21, 1959, at its regular monthly meeting held at the University Health Center.

Case No. 67. The patient is an 80 year old white woman with a history of bleeding for two months. Pelvic examination revealed cervix replaced by necrotic fungating mass. Tumor extended to left pelvic wall and partially into right parametrium. Patient was referred by her family physician. Complete diagnostic evaluation was done including chest x-ray, barium enema, and intravenous pyelograms. These were all within normal range. Patient scheduled for radioactive cobalt central therapy and external x-ray to follow. Dosage schedule plan was 7000 r. to point "A," with two applications of radioactive Co⁶⁰ in colpostat and fandem. This to be followed with 4000 r. tumor dose external x-ray therapy.

Patient refused therapy and was discharged against advice.

Comments

DR. POMEROY: We are still faced with the need of preliminary education of these patients to accept treatment. All too often the diagnosis of carcinoma leaves the patient with a feeling of hopelessness and, accordingly, she feels that it is useless to have any form of treatment.

DR. EZELL: This is particularly true in those cases wherein another member of the family has died with a similar disease.

DR. HOLLENBECK: The educational system is rapidly bringing a reversal in the numbers of patients seen in the different stages. Previously, we saw 90 per cent of our patients in Clinical Stages III and IV. We are now seeing 90 per cent of our patients in Clinical Stages 0, I and II. This is the single, most heartening thing that we have found in recent years.

DR. HOLZAEPFEL: Apparently we are overcoming some of the prejudices and suspicions but we have a great way to go, among both laymen and the medical profession, before there is any time lost in the treatment of cancer. We still must overcome the hopeless attitude seen in this individual.

Prostatic Cancer

A survey of the chairmen of departments of urology in the nation's medical schools indicates 53 out of 54 treat early prostatic cancer by radical surgery. It is imperative that more frequent rectal examinations on men be carried out and that all suspicious lesions be subjected promptly to biopsy so that radical surgical treatment may be carried out when indicated.—J. H. Arnold, Houston: *Texas State J. Med.*, 55:91, February, 1959.



MATERNAL HEALTH IN OHIO

Case No. 91

This patient was a 34 year old white female, gravida III, Para II, 12 weeks gestation, who died undelivered six hours after hospital admission. Past history uneventful except for bruising easily and a history of recent "infected mosquito bites." Last menstrual period was April 1; she did not consult a physician. Patient began to vomit blood and hemorrhage per vagina on July 13, the morning of admission. The admission red blood cell count 1.85 million, diminished to 900,000; hematocrit 11 per cent, prothrombin time 14 per cent after initiation of therapy. Patient denied any attempt at abortion.

Despite the usage of fibrinogen, whole blood, Hykinone®, calcium gluconate and penicillin, the patient rapidly became moribund. Liver enlarged rapidly to 9 cm. below costal margin. Postmortem blood culture positive for *Escherichia coli*. Given "A-negative" blood because of insufficient cells for Rh type.

Cause of Death: (a) Acute septicemia and peritonitis; (b) self-inflicted abortion; (c) death of mother and fetus.

Pathologic Diagnosis: (Coroner's autopsy). Intra-uterine fetal death (fetus 16 cm.); afibrinogenemia; aprothrombinemia; acute myometritis; septic placental necrosis; acute hemolytic *E. coli* septicemia; quinine ingestion; acute peritonitis effusion 1500 cc; pleural effusion 1600 cc.

Comment

The Committee voted this a preventable maternal death, patient responsibility P₁. It was thought that all had been done for this patient that could have been done. This was considered to be a self-inflicted abortion on the basis of quinine ingestion and the unofficial autopsy finding of perforation of the abdomen of the fetus. The problem of septic abortion with hemolytic anemia and overwhelming sepsis always presents a difficult and lethal problem to combat.

Case No. 142

This patient was a 27 year old white female, gravida V, Para IV; at approximately 12 weeks gestation, who died 45 hours after hospital admission. Past history and date of last menstrual period not known. The husband denied criminal intervention, although a sister had allegedly had several criminal abortions. Approximately three months pregnant, the patient was apparently well until two days before admission, when she experienced bleeding and cramps, followed by fever and chills on the day of admission. She had passed, spontaneously, a 19 cm. male fetus with extensive maceration; moderate autolysis of placenta which, microscopically, showed great numbers of bacterial colonies. On March 19, admission temperature was 40°C; white blood cell count was 3,000 with 68 per cent polymorphonuclear leukocytes, hemoglobin 11.2 Gm., red blood cell count

TOPIC THIS MONTH:

Maternal Deaths* Involving Abortion and Sepsis

4,200,000; also on March 19 the blood culture was positive for *E. coli*.

Despite the usage of streptomycin and penicillin, Achromycin®, cortisone and Chloromycetin®, the condition of the patient deteriorated rapidly. She was in a continuous state of shock which did not respond to digitalis, dextran and Levophed®. Autopsy permission was not obtained.

Cause of Death: (a) Septicemia and bacteremia; (b) complete abortion with endometritis.

Comment

After studying this case the Committee voted this a preventable maternal death, from overwhelming sepsis, patient responsibility P₁. It was felt, however, that had sensitivity tests been performed at the time blood culture revealed *E. Coli*, specific therapy could have been started sooner.

In this patient, also, the characteristics of septic shock are evident, i. e., a high temperature and pulse in a critically ill patient who later becomes pulseless, with severe hypotension. Usually this particular hypotension does not respond to whole blood but may be helped by norepinephrine administration; it was not used in this case.

Case No. 300

This patient was a 35 year old, white married female, gravida V, Para IV, who died in the eighth week of gestation. She died after approximately four days of hospitalization. Previous history of other deliveries was negative. This patient attempted to abort herself by means of a catheter; eight days later she developed pain and stiffness of the jaw. She was hospitalized July 14 and treated unsuccessfully for tetanus. Details of labor-

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by official representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

atory findings and therapy are not reported; history of hospitalization could not be obtained. Autopsy was performed.

Pathologic Diagnosis: (Coroner's report.) Bilateral pulmonary congestion and edema; severe endometritis with incomplete abortion of uterus; endometritis of ovary; moderately severe cerebral edema; clinical tetanus, confirmed by bacteriological isolation; self-induced abortion.

Comment

Again, the Committee voted this a preventable maternal death, (P₁) patient responsibility. The development of tetanus is a less common complication which may accompany septic abortion. Committee members, regretting that details of therapy were not reported, could only guess at type and quantity of medication which were used in the case.

Comment of Consultant

The following comment of a consultant, a medical examiner who is an expert in medicolegal problems, was given at the request of the Committee.

The brief information furnished in the three cases cited leads to the presumption that all were abortions. Whether the abortions were induced by the patient or another party is of no particular significance in influencing the choice of proper treatment. However, the means by which the abortion was induced must be determined in order to arrive at a complete and accurate diagnosis as a basis for instituting effective therapy. From a purely medical viewpoint it is mandatory that the physician determine whether the abortion was *induced* or *spontaneous*.

The significance of such differentiation in influencing therapeutic measures in the postabortal state as well as in precautionary measures in future pregnancies must be recognized.

It is generally acknowledged that:—*The most frequent fatal diseases following a criminal abortion are due to infections. Severe and fatal infections are much rarer after therapeutic or spontaneous abortions than after criminal abortions.* (Gradwohl) Therefore, the attending physician must suspect every infected case of abortion to be induced by the patient or others. **He must be aware of the medicolegal aspects of such cases.** He may be dealing with a criminal abortion for which the person responsible could be prosecuted if sufficient evidence were developed. The role of the physician in the recognition and preservation of such evidence is of major importance in protecting society from further activity of the abortionist.

The physician must conduct a thorough examination and keep an accurate record of the objective findings. These must include: (1) Evidence of pregnancy; (2) Evidence of abortion; (3) Evidence of whether the abortion was spon-

taneous or induced, and if induced, (4) Evidence of the method used. Space assigned here does not permit any discussion of the objective signs which are described in many textbooks. The anatomic findings and medicolegal implications are correlated in *Practical Forensic Medicine* by Camps and Purchase, and *Legal Medicine*, edited by R. B. H. Gradwohl.

The summaries of the cases submitted for study here indicate a general disregard of the medicolegal implications of abortion cases as reflected in (1) a complete lack of concept of significance of obtaining a complete history or performing a thorough physical examination for the purposes of demonstrating or clarifying the suspicion as to whether or not the abortion was induced; (2) a disregard of the duty to recognize and preserve evidence for the coroner and other law enforcement agencies.

The information abstracted from the autopsy reports is inadequate for medicolegal assessment and leads to inferences and conclusions that may not be justified. On the basis of the information submitted, this writer is reluctant to comment on the diagnosis and treatment and while concurring with the general classification of "preventable maternal death, patient responsibility" would urge that specific action be taken in an attempt to devise some *preventive* measures to reduce the number of such cases in the future.

Certain violations of medicolegal principles in the cases submitted for review can be pointed out.

Case No. 91: Although symptoms of visual and auditory impairment are not reported it could be inferred that this patient had some symptoms which were consistent with quinine intoxication. One might suspect that the "infected mosquito bites" actually might have been urticarial wheals which frequently are seen in quinine intoxication. The bloody vomitus, vaginal hemorrhage, hemolytic anemia and hypothermia are consistent with quinine intoxication. A history of anuria or reports of examination of the urine, kidneys or liver would have been significant since hemoglobinuria or anuria is seen in quinine intoxication. (See Glaister: *Medical Jurisprudence and Toxicology*, p. 670; Salter: *Textbook of Pharmacology*, p. 56; Pirk and Engelberg: "Hypothermic Action of Quinine Sulfate," *J.A.M.A.*, 128:1093.)

If the clinical diagnosis of quinine intoxication had been made and the patient questioned concerning the ingestion of quinine rather than the attempt at abortion it is not unlikely that the suspicion would have been resolved. Such procedure is in accordance with accepted practices

in the art of interrogation where one of the cardinal rules is to state known facts and request specific information. In this case such information might have suggested the advisability of gastric lavage and evacuation of the uterus as prophylactic measures.

The *Cause of death* could have been more accurately stated and would better describe the circumstances if ascribed to (b) *attempted* abortion (self-induced); (c) death of fetus *in utero*; death of mother. This is a matter of semantics which is necessarily very important to the Bureau of Vital Statistics because of the brevity of the information on the death certificate.

Case No. 142: The absence of a thorough gross examination of the placenta and fetus or the examination of the patient points to the lack of concept of the significance of recognizing and preserving evidence in this type of medicolegal case. The finger of suspicion is pointed at the husband by inference but apparently no attempt was made to obtain evidence which would be proof of either his guilt or innocence. It should be recognized that proof of innocence is equally as important as the proof of guilt.

The statement that autopsy permission was not obtained demonstrates an *ignorance* of the law (assuming that this death occurred in Ohio). The law of this state requires that: "When any person dies as a result of criminal or other violent means, or by casualty, or suicide, or suddenly when in apparent health, or in any suspicious manner, the physician called in attendance shall immediately notify the coroner of the known facts concerning the time, place, manner and circumstances of such death, and any other information which is required pursuant to sections 313.01 to 313.22, inclusive, of the Revised Code." **This case was certainly suspected to be due to violence.** The coroner is charged with the duty to determine the cause, mode and manner of death. The coroner has the authority by law to perform an autopsy or have an autopsy performed at his direction. (Sec. 313.13.) No further permission is required and should not be requested from the family by the hospital since *such a case is out of their jurisdiction* when death occurs.

Case No. 300. The history imparts the information that the patient attempted to abort herself by means of a catheter. This is certainly a case of death resulting from violence. This fact was known to the hospital and yet we are informed that the history of hospitalization could not be obtained. The report of the coroner's autopsy signifies that the death was reported to that authority. Attention should be called to the fact

that the coroner has the *right and duty to obtain hospital records* and to make pertinent information part of the coroner's report. Since the coroner's office is a medicolegal agency it should be expected that hospitals would cooperate willingly with the coroner and supply him with the necessary information as requested. Should they fail to do this the coroner has the authority by law to subpoena such witnesses as are necessary. (Sec. 313.17 Revised Code of Ohio)

Although no one is certain of its magnitude it is generally acknowledged that illegal abortion is a major problem in the United States. However, if one scans the recent medical literature of the United States he finds almost no reports to substantiate this impression. This writer would suggest that if accurate and detailed records kept by individual physicians as well as hospitals were compiled by the Committee on Maternal Health it would be possible to arrive at some concept of the actual magnitude of the problem and perhaps devise effective means for combatting the misinformation and vicious hoaxes purveyed surreptitiously to distraught and gullible women.

Suggestions Concerning Problem Of Pertussis

In spite of the statistical evidence that the incidence of pertussis is decreasing, this disease is still important for several reasons. The mortality rate in infants is still high. Some immunized children may still be susceptible to the disease. Broad-spectrum antibiotics are effective if used in the early stages of the disease. Use of antibiotics prior to an attempt to establish a positive etiologic diagnosis may make later attempts unsuccessful.

The following suggestions are in order concerning the problem under discussion: Knowledge of the atypical forms and variations of the clinical picture of pertussis may make the entity easier to suspect. Actual diagnosis is dependent upon isolation of the etiologic agent.

The physician must provide local means for carrying out bacteriologic isolation of *B. pertussis* (*Bordetella pertussis*). In carrying out active immunization procedures, correct knowledge of technique, precautions, contraindications, and immunization schedules may markedly increase the effectiveness of the immunization program.

All parents should be encouraged to have the complete immunization program for their infants.

The physician should consider pertussis as a possibility in all cases of upper respiratory infection, especially in the infant and young child.—James V. Miles, Jr., M.D., Jamestown, North Dakota: *J. Lancet*, 79:49, February, 1959.

Syphilitic Optic Atrophy

A Case Report on Preventable Blindness

WILLIAM H. HAVENER, M. D.

A BLIND EYE is a serious loss to both patient and community. Awareness of the preventable nature of a significant portion of this blindness should help in reducing the incidence of such tragedies. The representative cases to be presented here are selected to emphasize relatively common causes of blindness which can in many instances be averted by proper, timely care.

Case Report

During military service in World War I this 60 year old man developed a penile chancre. Therapy consisted of heavy metal injections. Eighteen years later gradually progressive blurring of vision affected first one eye, then the second. Within several years he became completely blind. Examination now shows complete atrophy of both optic nerves. Both spinal fluid and blood serologic tests for syphilis are 4 plus. The diagnosis is syphilitic optic atrophy and neurosyphilis.

Discussion

The false belief that the advent of penicillin has practically eliminated syphilis is often encountered. Actually, over 2,000,000 syphilitics live in the United States. Eight per cent of all blindness is of luetic origin. Most luetic blindness is due to involvement of the optic nerve, a manifestation of tertiary syphilis.

The most effective means of preventing blindness as a complication of syphilis, is, of course, recognition and adequate treatment of the early stages of the disease. Routine serologic screening is a most important means of detection.

The onset of blindness from syphilitic optic atrophy is most insidious and can readily be overlooked by both patient and physician. Fifteen years will usually have passed since the long-forgotten primary infection. The patient will be in his mid-thirties or older, an age group where the need for glasses increases. Visual symptoms will be vague and indefinite, and interpreted as simply a refractive error. Unfortunately, therefore, the disease will progress to the stage of early optic atrophy, field constriction, and reduced visual acuity before diagnosis. By this time a certain amount of irreversible structural damage will have occurred, usually bilaterally.

Prompt diagnosis through medical examination may yet prevent blindness if adequate penicillin therapy is begun. Several years delay during the stage of visual symptoms will lead to advanced and untreatable optic nerve damage. Many of those infected by syphilis are unbelievably careless about their health, often seeking no care at all for serious symptoms, or accepting an optometric refraction as a substitute for medical examination.

The Author

● Dr. Havener, Columbus, is on the attending staff at University Hospital, and Acting Chairman, Department of Ophthalmology, The Ohio State University College of Medicine.

Treatment of syphilitic optic atrophy is the same as for any other type of neurosyphilis. Current recommendations are for a total course of 7,200,000 units of a long-acting penicillin preparation. It is desirable to maintain a high concentration of penicillin for a prolonged time, therefore a typical course of therapy consists of six injections of 1,200,000 units of procaine penicillin in oil with aluminum monostearate at intervals of two to seven days. The long acting benzathine penicillin G may be used as three injections of 2,400,000 units every two to seven days. When large volumes are injected, dividing the dose and placing half in each buttock reduces pain.

If visual acuity is better than 20/50, it is probable that treatment will prevent further visual loss. Far advanced optic atrophy will often progress to blindness despite therapy. Perimetric examination is a very helpful means of evaluating the course of the disease.

It is evident from the foregoing discussion that the vigilance of the physician in detecting and treating stages of syphilis is the most effective means of preventing late syphilitic blindness. *Eight per cent* of our blindness is due to syphilis.

Intestinal Obstruction In the Newborn

Early diagnosis, proper surgical treatment, and alert, disciplined care will save a high percentage of the infants with congenital intestinal obstruction. One must never be satisfied with the comment "The baby died, but then, it was just a few days old." This is not an alibi—it is an indictment.—J. Eugene Lewis, M. D., St. Louis: *Missouri Med.*, 56:141, February, 1959.

A Clinicopathological Conference

Edited Under the Auspices of the Ohio Society of Pathologists

CHARLES BLUMSTEIN, M.D., *President*

Presentation of Case

THIS 64 year old white male first entered the University Hospital, Columbus, Ohio, with the chief complaint of "heart trouble" approximately one year before his demise. He had been well until six years prior to admission, when he awakened one morning with right-sided weakness including weakness of the right side of the face. The patient continued to work and noticed gradual improvement of the weakness over the next several months. Two years prior to admission he noted a gradual onset of exertional dyspnea, orthopnea and occasional ankle edema. He was digitalized at another hospital and remained asymptomatic until two weeks prior to admission to this hospital, when he again noted increasing exertional dyspnea, orthopnea and frequent paroxysmal nocturnal dyspnea. He denied any history of chest pain.

The patient's apical pulse was 140, his radial pulse 64; his blood pressure was 150/80. The patient was a well developed, well nourished white male with marked dyspnea at rest. There was a discrete nodule in the right lobe of his thyroid. The heart was enlarged to the anterior axillary line on the left at the level of the sixth rib. His cardiac rhythm was irregular and there was a grade 2 systolic murmur at the apex. The liver was palpable 4 fingerbreadths below the right costal margin.

The neurologic examination gave no significant findings. The serologic tests for syphilis were nonreactive. X-Rays of the chest showed a 35 per cent cardiac enlargement with predominance of the left ventricle. The electrocardiogram showed a rate of approximately 160; it was interpreted as showing rapid atrial fibrillation or premature ventricular contractions.

The patient was placed at strict bed rest and was treated with sedation, Digoxin® and diuretics. The endocrinology consultant felt that an iodine conversion ratio of 48 per cent was suggestive of thyroid hyperactivity and the patient consequently received 10 millicuries of I^{131} . A glucose tolerance test showed an elevated and delayed blood sugar curve with a fasting blood sugar of 139 mg. On the day of his intended discharge the patient suddenly developed severe pain and cyano-

Presented by

- Hugh B. Hull, M.D., Columbus, and
 - Emmerich von Haam, M.D., Columbus.
- Edited by Dr. von Haam.

sis from the left mid thigh to the foot. A left femoral artery embolectomy was performed successfully two hours after onset of symptoms.

The patient was readmitted two months later with chief complaints of headache, ptosis of the left eyelid, blurring of vision and diplopia. He denied weakness of his extremities, face or tongue. He also complained of 2-pillow orthopnea but denied pedal edema and excessive exertional dyspnea. His pulse was 76 and irregular, his blood pressure 138/90. His heart was enlarged as before; there was a grade 2 inconstant murmur and an irregular rhythm. His basal metabolic rate was plus 20; his fasting blood sugar was 195 mg. His electrocardiogram was interpreted as showing atrial fibrillation and digitalis effect.

The patient was treated with Digoxin, sedation and quinidine and was discharged five days later. He was followed in the Cardiac Clinic, where quinidine and diuretic therapy was continued. He was readmitted to the hospital on two subsequent occasions for diuresis and thoracenteses.

The fifth and last admission occurred one year after his first. His complaints and physical findings were essentially those seen on previous admissions except for severe anasarca and marked jugular vein distention. His chest x-ray showed a right pleural effusion. His electrocardiogram was interpreted as showing atrial fibrillation, combined ventricular enlargement and myocardial damage.

Thoracenteses were performed and the patient was placed on a strict diet with appropriate medications. He developed coldness of his left foot with an area of demarcation 10 cm. above the ankle. Sympathetic nerve block and anticoagulant therapy improved his circulation. He suffered occasional episodes of vomiting and nocturnal disorientation. Easy fatigability became more pronounced and it was felt that fluid was again

accumulating in his chest. The patient died quietly during sleep on the fifteenth hospital day.

Clinical Discussion

DR. HULL: This 64 year old white male was admitted to University Hospital five times during one year with heart trouble. I presume he was 64 on his last admission. At the age of 57 he had what apparently amounted to a little stroke. About four years later he developed for the first time symptoms of heart failure and was successfully treated in another hospital with digitalis and diuretics. After being asymptomatic for the next two years he again developed exertional shortness of breath, orthopnea and paroxysmal nocturnal dyspnea and two weeks later had his first admission to University Hospital.

On examination it was found that he had a very rapid and irregular heart rate and the electrocardiogram showed "rapid atrial fibrillation or premature ventricular contractions." I would wonder if he did not have both. The heart was enlarged both by physical and x-ray examinations but was not too remarkable on auscultation. An inconstant grade 2 systolic murmur was heard over the apex, which of course would be suggestive of mitral regurgitation. In an individual of this age with mitral regurgitation one might expect also evidence of mitral stenosis, which he did not have. He must have been in pretty severe failure with an enlarged liver and congested lungs with pulmonary edema.

His glucose tolerance test proved him to be also a mild diabetic, although he did not require insulin. An endocrinology consultant felt that his persistent tachycardia and his iodine conversion ratio suggested thyroid hyperactivity and he received 10 millicuries of radioactive iodine. Just before his discharge he threw an embolus into his left femoral artery, which was removed two hours later.

He did not stay healthy very long and came back in two months with complaints of severe headache, ptosis of the left eyelid, blurring of vision and diplopia. At this time his pulse was again irregular and the electrocardiogram showed atrial fibrillation. He had no other neurological difficulties. His heart was enlarged and there was a grade 2 inconstant systolic apical murmur. His basal metabolic rate was plus 20, which on a single examination probably is not too significant. Heart failure for that matter may increase the basal metabolic rate to a certain extent, although he apparently was not in severe failure at this time. He was given quinidine and his rhythm again became normal.

He did not do too well and had to be read-

mitted to the hospital on two occasions for diuresis and thoracentesis. Then ten months later he was admitted for the fifth and last time. He now had severe anasarca, marked jugular vein distention, atrial fibrillation and right pleural effusion. He died quietly on his fifteenth hospital day.

Failure Obvious—Etiology Obscure

It seems to me pretty obvious that this man had severe progressive heart disease. The thing that is not obvious is what kind of heart disease it was. There is a tendency with any patient of this age with heart disease which does not fit into the other common categories, just to say, "Well, this must be arteriosclerotic heart disease." This is a mistake. If we do this we ultimately stop thinking about etiology. In order to make a diagnosis of arteriosclerotic heart disease with any degree of certainty we have to have some evidence for a decreased arterial supply to the myocardium. Clinically of course this could be recognized by the symptoms of angina pectoris, or electrocardiographically by some disturbance in conduction. This man did not have any history of chest pain and at no time when he was observed pretty closely in the hospital did he have chest pain. The electrocardiogram did not show a complete heart block or even a bundle branch block. So I don't think we are justified in assuming that he had arteriosclerotic heart disease.

Let us consider then other possibilities of heart disease. He is a little bit too old for the diagnosis of congenital heart disease. As for rheumatic heart disease, there is only the suggestion that he had an apical systolic murmur which was inconstant. Also his x-rays are not particularly suggestive. Initially he had symptoms of left ventricular failure with shortness of breath, orthopnea, paroxysmal nocturnal dyspnea, with only minimal edema. Only subsequently did he develop all signs of severe right-sided failure with marked anasarca and venous distention. So that if he had a valvular abnormality it must have been pure mitral regurgitation or aortic stenosis. The latter may occasionally be associated with a murmur that is heard better over the apex than over the aorta, but again this condition should not be difficult to recognize on reasonably adequate physical examination.

Since he was not hypertensive I don't think we need consider hypertensive heart disease as a very good possibility. His serologic test for syphilis was negative and he had none of the findings that we associate with syphilitic heart disease.

Exotic Causes

This leaves us then with types of heart disease of more obscure etiology. Since he had diabetes

one wonders if perhaps he had hemochromatosis. But there was no mention of pigmentation of the skin and I don't think we have any justification for saying that he had hemochromatic heart disease. There may be nutritional heart disease, of which beriberi is an excellent example, but we have no reason to think that he suffered from any nutritional problems. Isolated myocarditis (Fiedler's) may occasionally give rise to a picture like this. However, usually its course is a little more rapid, something on the order of a few months rather than several years, as it was in our case. Still the possibility of some type of myocarditis has to be strongly considered.

Closely related to this condition would be endomyocardial fibrosis. This does not represent an etiological diagnosis because we don't know the etiology of endomyocardial fibrosis. It is fairly common in some parts of Africa, although it does occur elsewhere and I think it has to be considered as a strong possibility. There is also the possibility of sarcoidosis, but the patient had nothing else to suggest sarcoidosis. Another possibility would be primary amyloidosis. Commonly in primary amyloidosis there may be other evidence of amyloid deposits, such as thickening of the tongue, but occasionally the amyloidosis is confined pretty much to the myocardium. I am not sure that I would have any way of distinguishing clinically between primary amyloidosis, endomyocardial fibrosis or myocarditis.

Electrocardiogram Not Helpful

The electrocardiogram is also of not much help in the differential diagnosis. Had there been EKG evidence of an old myocardial infarction, I think it would have helped considerably in making a diagnosis, but in the absence of that I would have to presume that it is something other than arteriosclerotic heart disease. However, I would like to point out that it is possible to have arteriosclerotic heart disease without EKG evidence of myocardial infarction. It is not at all uncommon for an individual to have an infarct with electrocardiogram changes and subsequently to have these changes disappear, or there may never have been an electrocardiogram diagnostic of an infarct to begin with. So the fact that he did not have EKG changes suggestive of arteriosclerotic heart disease does not at all rule out this possibility.

Thyrotoxicosis?

I think that his heart condition might also be consistent with thyrotoxicosis except that I would expect marked cardiac improvement once his thyroid condition had been gotten under control, and he should have continued to improve unless his thyrotoxicosis resulted in some irreversible toxic

damage on the order of a myocarditis. But I am not convinced that he had thyrotoxic heart disease and I am certainly very reluctant to accept thyrotoxic myocarditis as the cause of his ultimate demise.

Multiple Emboli

This man evidently had repeated attacks of embolization. He probably had emboli when he was fibrillating, since atrial fibrillation predisposes to formation of thrombi in the atria which may be dislodged and produce emboli. Endocardial thrombosis is not at all uncommon in cases of endomyocardial fibrosis, so that the fact that he had on several occasions apparently thrown off emboli would very strongly support such an etiology. Whether or not the first episode six years before his admission was on an embolic basis, I don't know.

I think the symptoms and signs produced by a cerebral embolus are dependent upon the size of the vessel and where it happened to hit. His emboli apparently involved only small parts of his brain and probably a good bit of the initial difficulties were due to associated vasospasm and edema in the area surrounding the embolus. But since these changes are reversible, it is possible to recover from most of the symptoms. This sort of picture is not too uncommon in cases of subacute bacterial endocarditis, where the patients throw off small cerebral emboli and have transient episodes of diplopia.

Clinical Diagnosis

1. Progressive heart failure due to organic heart disease, possibly myocarditis or endomyocardial fibrosis.
2. Multiple emboli.
3. Mild diabetes.
4. Bilateral hydrothorax.

Pathological Diagnosis

1. Chronic myocarditis with congestive heart failure.
2. Multiple infarcts to spleen and kidneys due to multiple embolism.
3. Fetal adenoma of thyroid.
4. Hydrothorax, right.

Pathological Discussion

DR. VON HAAM: The clinical diagnosis at the time of the patient's death was arteriosclerotic heart disease. The autopsy revealed a normally nourished and normally developed body with a minimal amount of sacral and pedal edema. The right pleural cavity contained about 500 cc. of clear yellow fluid.

The heart was markedly enlarged and weighed

560 grams. Both ventricles appeared distended and the heart muscle was soft and flabby. The mural endocardium showed discrete white fibrotic lesions. The valves showed no deformities or vegetations. All coronary vessels were remarkably patent and pliable. Sections through the myocardium revealed irregular whitish fibrous areas and scattered petechiae scattered throughout both ventricles. There was no evidence of recent or old infarction.

The lungs appeared mildly emphysematous with some fibrous nodules. The spleen contained an old infarct. The liver and the gastrointestinal tract appeared congested. The kidneys also contained several small old infarcts. The thyroid gland contained a soft, fleshy nodule. The brain appeared completely normal.

Microscopic Examination

Sections through the heart muscle revealed patchy myocardial and subendocardial fibrosis surrounded by some irregular myocardial hypertrophy. There were also present small foci of inflammatory cells, mostly histiocytes with a few eosinophilic leukocytes. In some foci fibrosis and inflammatory cells were both present. All coronary vessels appeared normal and no collateral circulation was present. Fat and amyloid stains were negative. The microscopic picture was that of focal myocarditis leading to local myocardial fibrosis. The picture was definitely not that of rheumatic myocarditis or of Fiedler's isolated myocarditis, but rather that of nonspecific chronic myocarditis as described by Saphir¹. The presence of eosinophilic leukocytes would suggest the presence of an allergic factor in the inflammatory process.

The picture is also not compatible with changes found in thyrotoxicosis, and histologic examination of the thyroid nodule revealed a fetal type of adenoma, which is not hyperactive. The remaining organs showed only chronic congestion with old infarcts in the spleen and kidney. Microscopic examination of the brain failed to detect any morphologic changes responsible for his two periods of neurologic symptoms.

In conclusion I must agree with Dr. Hull and state that this patient suffered from chronic myocarditis of undetermined etiology leading to left ventricular and later right ventricular failure. This case should remind us that the old and forgotten concept of chronic myocarditis still exists as a disease entity and can be responsible for intractable and fatal cardiac failure.

Reference

1. Saphir, O.: Myocarditis. A General Review, with an Analysis of 240 Cases. *Arch. Path.*, 32:1000-1051, 1942; 33:88-137, 1943.

Antihypertensive Therapy as Viewed in Perspective

As physicians seeking the truth we must maintain an objective attitude at all times. In antihypertensive therapy each of us must establish goals that seem rational and advisable and then measure as accurately as possible how well these goals are achieved. Premature reports of a favorable nature concerning antihypertensive drugs arouse false hopes in thousands of hypertensive patients. The failure of many such drugs to live up to their advance billing has disappointed many patients. But worse, in my opinion, is the fact that each such instance has served to weaken the confidence of the public in the medical profession.

It is the duty of every physician to protect his patient and his profession for the mutual benefit of each. A sage, objective approach to medicine and its countless problems serves this function. Failure to use this approach in evaluating the treatment of hypertension does not serve the patient well, and worse, constitutes a form of self-deception on the part of the physician.

Until we obtain the crucial facts about the cause of essential hypertension or until we accidentally stumble upon a specific form of treatment for it, truly adequate treatment for most hypertensive patients is out of reach. Once such treatment becomes available, most of the conflicting reports concerning the efficacy of antihypertensive therapy will be resolved. In the meantime we must do the best we can with what we have available. At the same time we must retain both a sense of intellectual balance and the objective approach we owe to the patient and to the profession. —J. Earle Estes, Jr., M. D., *Proc. Staff Meet., Mayo Clin.*, 33:326, June 11, 1958.

Herpetic Keratitis

At present, corneal transplanation is the only definitive means of controlling or terminating recurrent or chronic herpetic keratitis. Of 48 keratoplastic operations for various forms of corneal herpes, 16 in quiescent cases and 32 in cases of active keratitis, all but three brought about improvement.

Recurrence of keratitis in the graft is particularly likely if the visible lesion is not excised completely and a portion of the graft border lies in contact with diseased tissue.

The mode of action of corneal transplantation in improving herpetic keratitis is not clear but several possibilities have been suggested. At least in chronic stromal herpes the removal of diseased and necrotic tissue appears to be a very important factor.—Max Fine, M. D., San Francisco: *California Med.*, 90:121, February, 1959.

New Forand Bill . . .

Same Old Proposal With A Few New Wrinkles In Hopper of Congress;
Some of Its Provisions, as a Social Security Measure Outlined in Article

THE Forand bill for hospitalization and surgical services of retired social security recipients and their dependents has been introduced in the Congress in only slightly revised form. Its number is H. R. 4700. One change of interest is permitting surgical services to be performed by other than board-certified surgeons.

The author says the program will be financed by increasing social security taxes (above increases already scheduled) by one-fourth of one per cent for both employer and employee and three-eighths of one per cent for the self-employed, both starting in 1960.

The AMA has consistently opposed legislation of this type.

On hearings, little is known. Neither the House Leadership nor Chairman Wilbur Mills of Ways and Means Committee have given any indication when hearings would be held.

Detailed Provisions

The bill provides that the cost of up to 60 days of hospitalization in any twelve-month period would be paid from the Federal Old-Age and Survivors Insurance Trust Fund. Up to 120 days in a twelve-month period (less the number of days of hospitalization) of nursing home services would be furnished an individual who is transferred to a nursing home from a hospital, if the services are for an illness or condition associated with that for which he was hospitalized.

"Hospital services" are defined as services, drugs, appliances furnished by a hospital to any individual as a bed patient in semi-private accommodations and includes nursing service, laboratory services, ambulance, use of operating room, and staff services. The term would not include care in any tuberculosis or mental hospital.

"Nursing home services" means skilled nursing care, related medical and personal services, and the accompanying bed and board furnished by a facility which is equipped to provide such services and which is operated in connection with a hospital or in which such skilled nursing care and medical services are prescribed by, or performed under the general direction of, a licensed physician.

"Surgical services" would include a surgical procedure, other than elective surgery, provided in a hospital, or in case of an emergency or for minor surgery, provided in an out-patient department or

a doctor's office. It would include oral surgery when provided in a hospital by a licensed dentist. An eligible individual would be able to choose the hospital, nursing home or physician, provided he selects one which has entered into an agreement to provide such services. Except in an emergency, the surgeon would have to be certified by the American Board of Surgery or by any of the medical specialty boards in the surgical specialty field, by a fellow of the American College of Surgeons or have been appointed to the attending surgical staff of a hospital accredited by the Joint Commission on Accreditation of Hospitals.

Agreements Proposed

Agreements with a hospital or nursing home would provide for the furnishing of services as defined above. Such services would not be furnished except on written certification by the attending physician that hospitalization or nursing home care is medically necessary. Payments to a hospital or nursing home under an agreement would be on the basis of reasonable cost and would preclude any charges to the patient except in the case where the individual had requested more expensive than semi-private accommodations.

The Secretary would also enter into agreements with qualified providers of surgical services and which would stipulate fees which would constitute full payment. The agreements could be made by an association or organization representing the physicians or dentists. Provision is made for regulations under which payments would be made for services rendered in an emergency situation by a hospital, nursing home or physician not a party to an agreement.

A National Advisory Health Council would be established to consult with the Secretary of HEW.

Fort Steuben Academy

"Which Goiters Are Best Treated by Surgery and Which by Radioactive Iodine?" This question was discussed at the March 10 meeting of the Fort Steuben Academy of Medicine, Steubenville by Dr. Edward H. Ryneerson, chairman of the Section on Metabolic Diseases, Mayo Clinic; and Dr. Charles D. Hershey, on the surgical staffs of Steubenville, Wheeling and Martins Ferry hospitals.

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The possibility of gastric distress from either salicylamide or corticosteroid is minimized because of lower dosage required. This is further reduced by the buffer action of aluminum hydroxide. And the ascorbic acid helps meet the increased need for this vitamin in stress conditions. Because of the low dosage, side effects with Aristogesic have been relatively infrequent and minor in nature. However, more serious side effects have traditionally been observed on all corticosteroid therapy. Patients on long-term Aristogesic therapy should, therefore, be observed carefully.

Annual Meeting Guest Speakers . . .

Here Is Resumé of Visitors from Other States Who Will Speak at the Columbus Meeting, April 21-24; Many Other Features also Are in Store

GUEST speakers play important roles in the 1959 Annual Meeting program. Planners of the program arranged to have an excellent group of guests to participate in addition to the Ohio physicians who are scheduled to take part in the meeting in Columbus, April 21-24, inclusive.

For the benefit of physicians who wish to make a special effort to hear some of these guest speakers, the following list is given.

Consult the March issue of *The Journal* for the entire program—a truly outstanding compilation of postgraduate courses compacted into a four-day period.

TUESDAY, APRIL 21

Morning Cancer Program

C. Bernard Brack, M. D., Baltimore, Md., Associate Professor of Gynecology, Johns Hopkins University School of Medicine. Panel discussion on Treatment of Uterine Cancer.

Alexander Brunschwig, M. D., New York, N. Y., Professor of Clinical Surgery, Cornell University Medical College, New York. Panel Discussion on Treatment of Uterine Cancer.

Gilbert H. Fletcher, M. D., Houston, Texas, Professor of Radiology, The University of Texas Postgraduate School of Medicine. Panel discussion on Treatment of Uterine Cancer.

Edgar L. Frazell, M. D., New York, N. Y., Assistant Professor of Clinical Surgery, Cornell University Medical College, New York. Subject: Thyroid Cancer:

Raymond W. Houde, M. D., New York, N. Y., Associate, Sloan-Kettering Institute for Cancer Research. Subject: Control of Pain in the Cancer Patient.

Tuesday Afternoon Cancer Program

Michael R. Deddish, M. D., New York, N. Y., Clinician, Sloan-Kettering Institute for Cancer Research. Panel discussion on Cancer of the Gastrointestinal Tract.

Samuel P. Harbison, M. D., Pittsburgh, Pa., Professor and Chairman, Department of Surgery, University of Pittsburgh School of Medicine. Panel discussion on Cancer of the Gastrointestinal Tract.

Edward S. Judd, Jr., M. D., Rochester, Minn., Professor of Surgery, Mayo Foundation of University of Minnesota. Panel discussion on Cancer of the Gastrointestinal Tract.

Edward M. Litin, M. D., Rochester, Minn., University of Minnesota Postgraduate School Faculty. Subject: Should the Cancer Patient Be Told?

Tuesday Afternoon Heart Program

Arthur Grollman, M. D., Dallas, Texas, Professor and Chairman, Department of Experimental Medicine, Southwestern Medical School of the University of Texas. Panel discussion on Hypertension.

H. Mitchell Perry, Jr., M. D., St. Louis, Mo., Director, Hypertension Division, Department of Internal Medicine, Washington University School of Medicine. Panel discussion on Hypertension.

WEDNESDAY, APRIL 22

Alvin J. Cummins, M. D., Memphis, Tenn., Associate Professor of Medicine, University of Tennessee. Moderator of panel and discussant from standpoint of the internist on Differential Diagnosis and Management of Gastric Ulcer, in the combined session of the Sections on General Practice, Internal Medicine and Surgery.

John C. Saunders, M. D., Orangeburg, N. Y., Principal Research Scientist (Pharmacology), Research Facility, Rockland State Hospital. Subject: Clinical Implications of Neurochemistry, before the Section on Nervous and Mental Diseases.

Alejandro Aguirre, M. D., Mexico, D. F., Professor of Pediatrics, National University of Mexico. Subject: Malignant Diseases of Children, before the afternoon General Session.

THURSDAY, APRIL 23

Bradley Copeland, M. D., New England Deaconess Hospital, Boston, Mass. Subject: Quality Control in the Laboratory, before the Conference on Laboratory Medicine.

William K. Bannister, M. D., Hartford, Conn., Associate Anesthesiologist, Hartford Hospital. Subject: The Physiologic Effects of Asphyxia Neonatorum, before the combined Session of

Sections on Anesthesiology and Obstetrics and Gynecology.

A. G. Kammer, M. D., Pittsburgh, Pa., Professor and Head of Department of Occupational Health, Graduate School of Public Health, University of Pittsburgh. Subject: **The Position of the Industrial Physician in Industrial Management**, before the Section on Industrial Management.

Eben Alexander, Jr., M. D., Winston-Salem, N. C., Professor of Neurosurgery and Head of Department of Neurosurgery, The Bowman Gray School of Medicine of Wake Forest College. Subject: **Hypothermia in the Management of Intracranial Aneurysms, and Management of Myelomeningoceles**, before the Section on Neurological Surgery.

John J. Conley, M. D., New York, N. Y., Clinical Professor of Otolaryngology, Columbia University College of Physicians and Surgeons. Subject: **Cancer of the Cervical Esophagus and Pharynx**, before the combined session of the Sections on Otorhinolaryngology and Radiology.

Chester A. Swinyard, M. D., New York, N. Y., Associate Professor of Medicine and Physical Medicine, New York University College of Medicine. Subject: **The Anatomical and Physiological Basis for Cerebral Palsy**, before the combined session of the Sections on Pediatrics and Physical Medicine.

Oliver Field, Chicago, Ill., Director, Bureau of Investigation, American Medical Association. Panel discussion on **Food Faddism**, before General Session.

K. L. Milstead, Ph. D., Washington, D. C., Director, Division of Regulatory Management, Bureau of Enforcement, Food and Drug Administration. Panel discussion on **Food Faddism**.

Maye A. Russ, New York, N. Y., Director, Food, Drug and Cosmetic Division, National Better Business Bureau, Inc. Panel discussion on **Food Faddism**.

Warren E. Whyte, Chicago, Ill., Attorney, Law Division, American Medical Association. Moderator of panel discussion on **Food Faddism** before General Session.

Oscar P. Hampton, Jr., M. D., St. Louis, Mo., Assistant Professor of Clinical Orthopedic Surgery, Washington University School of Medicine. Subject: **The Establishment of the Triage System**, before the General Session Symposium on Trauma.

Robert H. Kennedy, M.D., New York, N. Y., Former Professor of Clinical Surgery, New York University Postgraduate Medical School. Subject: **The Care of the Multiple Injured Patient**, before the General Session Symposium on Trauma.

FRIDAY, APRIL 24

Morning General Session

(Program presented by faculty and alumni of OSU College of Medicine)

Curtis P. Artz, M. D., Jackson, Miss., Associate Professor of Surgery, The University of Mississippi Medical Center. Subject: **Present Status of Intravenous Nutrition with Emphasis on Fat Emulsion**.

William Hamelberg, M. D., Charleston, S. C., Professor and Chairman, Department of Anesthesiology, Medical College Hospital and Medical College of South Carolina. Subject: **Modern Drug Therapy and Anesthesia**.

Arnold B. Kurlander, M. D., Washington, D. C., Assistant Surgeon General, Deputy Chief, Bureau of Medical Services, Department of Health, Education and Welfare. Subject: **Emerging Health Problems**.

Wilford B. Neptune, Boston, Mass., Associate, Overholt Thoracic Clinic. Subject: **Clinical Use of the Pump Oxygenator Without the Use of Donor Blood for Prime or Support During the Perfusion**.

Jack Widrich, M. D., Miami Beach, Fla., Director of Radiology, Mount Sinai Hospital. Subject: **Unrecognized Urinary Bladder Distention Producing Large Bowel Compression and Obstruction**.

Cyril T. Surington, M. D., Erie, Pa., President, Ohio State University College of Medicine Alumni Association. Will preside over morning General Session program presented by the Ohio State University College of Medicine faculty and alumni.

Afternoon General Session

(Presented by faculty and alumni of OSU College of Medicine)

C. Joseph DeLor, M. D., Columbus, Clinical Professor of Medicine, Director of Gastroenterology Division, Ohio State University College of Medicine, University Hospital. Subject: **Duodenal Ulcer — Some Observations on Its Pathogenesis**.

Maurice Galante, M. D., San Francisco, Cal., Assistant Professor of Surgery, University of California School of Medicine. Subject: **Combined Surgical and Radiological Management of**

Primarily Inoperable Carcinomas of the Head and Neck.

Paul I. Hoxworth, M. D., Ph. D., Cincinnati, Associate Professor of Surgery and Director, Division of Hemotherapy, Department of Surgery, University of Cincinnati College of Medicine. Subject: **Physicians' Responsibility in Transfusion.**

Robert A. Moore, M. D., Brooklyn, N. Y., Dean, College of Medicine, State University of New York College of Medicine. Subject: **Tumors of the Testes.**

College of Physicians Files Brief In Cutter Polio Case

The American College of Physicians has joined Cutter Laboratories in appealing the decision of January 17, 1958, of the Superior Court in Alameda County, Calif., awarding two children damages for polio infections allegedly resulting from the use of Cutter vaccine despite the jury's finding that Cutter Laboratories was not negligent.

In its amicus curiae brief the College of Physicians points out that "the creation of an absolute liability concept would greatly impair future progress. The introduction of new products and procedures would be stifled and mankind would be denied the continual advancement of medical science. . . . We believe that when, as in the cases before the court at this time, a biological is made according to strict government specifications and complies with the best scientific and productive knowledge available and when the manufacturer is absolved of all possible negligence by the jury, as this defendant was, no liability should be incurred when an injury occurs because of the user's own peculiar susceptibility or because of insufficient scientific knowledge at that time. To create such an absolute liability would be to saddle the world of medical science with an unfair burden . . . it is clear that researchers would be unwilling to try new drugs on patients, practicing physicians would be afraid to avail themselves and their patients of the new wonder drugs and pharmaceutical houses would not be willing to manufacture new products should this concept be applied, for it holds the defendant liable without fault and liable for the unknown."

"How can any scientist, physician, hospital or pharmaceutical producer become involved in any forward steps in medicine, no matter how surrounded by standards, if he is to be held responsible for knowledge that does not, and cannot, exist until the future unfolds."

New Anesthesia Ruling Made By WC Bureau

Under a recent ruling made by James L. Young, administrator, Bureau of Workmen's Compensation, a hospital which furnishes anesthesia materials to physicians who receive a professional fee for administration of the anesthesia materials may include the cost of such materials in the cost of in-patient per diem rates used in computing the hospital's contract with the Bureau. It becomes effective with contracts starting July 1, 1960. If it is the practice of a hospital not to furnish anesthesia materials, this new ruling will have no effect.

The ruling is the result of a recommendation made by The Council of the Ohio State Medical Association, to correct a situation where a hospital furnishing anesthesia materials either had to absorb the cost or charge the anesthesiologist. Under the new ruling any hospital desiring to supply the anesthesia material may do so and be sure of reimbursement through the in-patient per diem amount received from the Bureau of Workmen's Compensation.

Annual Tuberculosis Symposium At Saranac Lake Scheduled

The Eighth Annual Symposium for General Practitioners on Tuberculosis and Other Chronic Pulmonary Diseases will be held in Saranac Lake, New York, July 6-10. It is sponsored by the American Trudeau Society, the local Medical Society and the local and state academies of General Practice.

Details may be obtained by writing: Registrar, Chest Disease Symposium for General Practitioners, P. O. Box 627, Saranac Lake, N. Y.

Cleveland Anesthesiologists To Hear Dr. Griffith

Harold R. Griffith, M. D., Emeritus Professor of Anaesthesia, McGill University, Canada, will be the guest speaker at the Third Annual Rolland J. Whitacre Memorial Address, sponsored by the Cleveland Society of Anesthesiologists.

His talk is entitled "Adventures and Misadventures in Forty Years of Anaesthesiology." It will be given at a Dinner Meeting at the Tudor Arms Hotel in Cleveland on Wednesday evening, May 20. For Reservations please contact: Sidney W. Helperin, M. D., 20665 Centuryway, Maple Heights 37, Ohio.

Proceedings of The Council . . .

Heavy Docket Considered at Meeting on February 21 at Which Legislative Bills Were Reviewed and a Number of Committee Reports Received

A regular meeting of The Council of the Ohio State Medical Association was held at the Columbus Office Saturday afternoon and evening, February 21, 1959. All members of The Council were present. Others attending were: Mr. Wayne E. Stichter, Toledo, legal counsel, and staff members Nelson, Saville, Page, Edgar and Moore.

On motion duly made, seconded and carried, the minutes of the meeting of The Council held on December 13-14, 1958 were approved.

Membership Statistics

The Executive Secretary presented the following membership statistics: OSMA membership as of February 20, 1959—7,177 of which 6,291 have affiliated with the American Medical Association. These figures compare with the following as of December 31, 1958: OSMA—9,234; AMA—8,167.

Constitutions and Bylaws

By official action, The Council approved revised Constitutions and Bylaws submitted by the following county medical societies: Crawford; Hardin; Ross; and Trumbull; and amendments adopted to their Bylaws by the following county medical societies: Tuscarawas and Wayne Counties.

The Council by official action, approved re-issuance of copies of charters to the Licking County Medical Society and Muskingum County Medical Society, subject to confirmation by the House of Delegates at the 1959 Annual Meeting.

Annual Meeting

The Executive Secretary presented a report on plans for the 1959 Annual Meeting, following which the president was authorized to appoint a committee to judge the Scientific and Educational Exhibits.

The Executive Secretary reported with respect to place and dates for the 1964 Annual Meeting. After consideration, The Council voted to hold the 1964 Annual Meeting in Columbus on April 27-30.

Welfare-Retirement Programs

Doctor Artman presented a report on a meeting of the Auditing and Appropriations Committee on the morning of February 21, 1959, for the purpose of discussing a resolution which had been referred by the House of Delegates at the 1958 Annual Meeting to The Council for study. The

resolution asked for a study of the desirability and feasibility of having the OSMA establish a welfare fund for aged physicians and their families who might need financial assistance and the desirability and feasibility of a retirement income program for members of the OSMA under the sponsorship of the OSMA.

Following Doctor Artman's report, The Council adopted a progress report to be submitted to the House of Delegates at the 1959 Annual Meeting.

Auxiliary Amendments

Consideration was given to a proposed revised set of Bylaws to be voted on by the House of Delegates of the Woman's Auxiliary at the 1959 Annual Meeting of the Auxiliary. Several changes in the proposed amendments were recommended by Doctor Pitcher and Doctor Pease, members of the Auxiliary Advisory Committee who had met with representatives of the Auxiliary on the morning of February 21. The changes proposed by Doctor Pitcher and Doctor Pease were approved by The Council. The amendments, with the changes incorporated, were approved by official action.

OMI Nominees

A report of the Nominating Committee to present nominees for the Board of Directors of Ohio Medical Indemnity to be voted on at the annual stockholders' meeting of OMI in April, was presented by Doctor Artman, on behalf of himself and the other members of the committee, Doctor Petznick and Doctor Hopkins.

The committee reported that it would be necessary to nominate and elect a replacement for Doctor Dooley, who has accepted a full-time position as Director of Professional Relations for Ohio Medical Indemnity.

The committee placed in nomination the name of Doctor Frank Shively, Jr., Dayton, to succeed Doctor Dooley on the Board of Directors of OMI and recommended that The Council thank Doctor Dooley for his faithful and competent services on the OMI Board. The recommendations of the committee were approved by The Council.

The committee then renominated the following physician incumbents to serve on the OMI Board for the ensuing year and such nominations were approved by The Council: Perry R. Ayres, M.D., Columbus; H. M. Clodfelter, M.D., Columbus;

D. W. English, M.D., Lima; Charles N. Hoyt, M.D., Chillicothe; Robert S. Martin, M.D., Zanesville; J. Stewart Mathews, M.D., Wyoming; George L. Sackett, M.D., Cleveland; L. Howard Schriver, M.D., Cincinnati; Robert G. Smith, M.D., Circleville; Gordon M. Todd, M.D., Toledo; Edmond K. Yantes, M.D., Wilmington; Starling C. Yinger, M.D., Springfield.

The Nominating Committee then recommended the nomination for the ensuing year of the following incumbents as members of the OMI Board: Clair E. Fultz, Columbus; Fred D. Learey, Columbus; Msgr. Robert A. Maher, Toledo; Harold W. Slabaugh, Akron; David L. Temple, Dayton.

These nominations were approved by The Council.

The committee advised The Council that Mr. D. A. Endres, Youngstown, who has served for many years on the committee had requested that he be replaced as a board member. The committee recommended to The Council that The Council accede to Mr. Endres' request and that he be commended for his excellent services over the years on the OMI Board. This recommendation was approved. Attention was called to the fact that Mr. Richard M. Ross had resigned as a member of the Board and that it would be necessary also to replace Mr. James V. Walker on the Board, inasmuch as Mr. Walker finds that he is unable to attend Board meetings.

The committee placed in nomination for the three vacancies on the Board, the following, and such nominations were approved by Council: Mr. Stanley R. Mauck, Columbus; Mr. John Schoedinger, Columbus; Mr. Edgar O. Mansfield, Columbus.

On recommendation of the committee and by official action, The Council authorized the following to cast the votes of the Ohio State Medical Association, a stockholder, at the annual stockholders' meeting of OMI in April on all business matters coming before that meeting, including the election of directors placed in nomination by The Council at its meeting on February 21, 1959: Dr. H. M. Clodfelter, Columbus, or Dr. Edmond K. Yantes, Wilmington, or Mr. Charles S. Nelson, Columbus.

Free Choice Questions

The Council then considered a communication from the American Medical Association stating that all constituent State Associations were being asked for their views and opinions on the following basic points to assist the AMA's House of Delegates in its consideration of a report of the Commission on Medical Care Plans at the June meeting in 1959:

"1. Free Choice of Physician—Acknowledg-

ing the importance of free choice of physician, is this concept to be considered as a fundamental principle, incontrovertible, unalterable, and essential to good medical care without qualification?

"2. Closed Panel Systems—What is or will be your attitude regarding physician participation in those systems of medical care which restrict free choice of physician? These suggestions (those contained in the Report of the Commission) acknowledge that the policy of the American Medical Association to encourage and support the highest quality of medical care for all patients remains unchanged. They question, however, whether attitudes toward the free choice of physician and the closed panel system may be undergoing evolutionary change."

After a thorough discussion, The Council instructed the Executive Secretary to advise the American Medical Association that the policy of the Ohio State Medical Association on these questions are found in a statement of policy entitled, "Determination of the Ethical Status of Physicians Participating in Third-Party Medical Care Plans", officially adopted by The Council on December 15, 1957. Further, he was instructed to transmit to the AMA a copy of the official statement of policy and to call to the particular attention of the AMA the conclusions of said statement.

Venereal Disease Survey

A communication from Doctor Frederick H. Wentworth, Medical Coordinator of Disease Control Activities of the Ohio Department of Health, was then considered. The communication requested the Association to co-sponsor with the department a venereal disease survey through questionnaires to be sent by the department to Ohio physicians. By official action, The Council approved the survey and the co-sponsorship of the Association.

Committee Reports

By official action, The Council approved the minutes of the Committee on Laboratory Medicine held on January 18, 1959; the minutes of a meeting of the Committee on Traffic Safety held on February 15, 1959; and the minutes of the Committee on School Health held on February 8, 1959, with the exception of that part of the minutes of this committee which referred to legislative matters pending before the Ohio General Assembly, which committee recommendation was considered separately when other legislative proposals were discussed and acted upon.

VA Questions

The Council was advised that the Veterans Administration had agreed to insert in the fee

schedule covering Ohio a fee of \$25.00 for complete history and physical examination to determine diagnosis, upon prior authorization, as requested by the Ohio State Medical Association.

A letter from the Cleveland Academy of Medicine stating that in its opinion the Brecksville VA Tuberculosis Hospital might be used to advantage for the care of aged and chronically ill, should the Federal Government decide to make such hospital surplus, was discussed. The Executive Secretary was instructed to convey this information to the AMA.

Insurance Proposal

A communication requesting the Association to consider a group health and accident plan for members was read and discussed. By official action, The Council decided that such a plan should not be considered at this time.

Conference on Aged

The Executive Secretary reported on a conference held in the Columbus Office on February 18, 1959, sponsored by the Committee on Care of the Aged. In addition to nine members of the committee, the following attended the conference: representatives of all Ohio Blue Cross Plans; representatives of the Ohio Hospital Association; representatives of Ohio Medical Indemnity and a representative of Medical Mutual of Cleveland. The purpose of the conference was to discuss informally and unofficially, the situation in Ohio with respect to hospital and medical benefits for aged persons furnished through voluntary insurance programs and what should and can be done to expand the scope of such programs. The conference agreed that the Blue Cross plans, OMI and Medical Mutual of Cleveland should study the matter and endeavor to come up with a "package" proposal for later consideration.

By official action, The Council then considered a number of legislative proposals before the General Assembly and adopted a policy concerning each.

Attest: CHARLES S. NELSON,
Executive Secretary.

Value of Sabin's Polio Vaccine To Be Known This Year

The worth of attenuated, live poliovirus vaccine as a tool to fight poliomyelitis should be proved by the end of 1959, according to Dr. Albert B. Sabin, Cincinnati virologist.

By the end of the year data will be accumulated from field trials on approximately one million persons.

"There is no indication so far that there is any danger either to those who receive the vaccine or to

those who may pick up the virus from vaccinated individuals," he said in an interview reported in the current March 23 American Medical Association News.

Dr. Sabin's vaccine contains live polio viruses which have been "tamed," or reduced in strength.

The decision that ultimately will have to be reached is whether to continue to attempt to vaccinate a whole population by giving an as yet undetermined number of shots of inactivated virus (Salk) vaccine or to give the three types of attenuated live virus vaccine, which can be taken orally and may be expected to produce long-lasting immunity. Dr. Sabin declared.

Since 1957 he has been testing the vaccine under procedures recommended by the Expert Committee on Poliomyelitis of the World Health Organization. It has been used in Russia, Czechoslovakia, Mexico, Singapore, the Netherlands, Chile, Sweden, England and Japan.

The vaccine is given orally, two drops to a teaspoonful of syrup. The vaccine for the three types of poliovirus are given at four-week intervals.

Dr. Sabin noted that his vaccine—as opposed to the "killed" virus vaccine—produces a complete or partial resistance to subsequent multiplication of polioviruses within the intestine. He believes that his vaccine could be used to supplement the partial immunity produced by Salk vaccine.

Dr. Sabin is professor of research pediatrics at the University of Cincinnati College of Medicine.

Hopkins Clinic Corporate Practice Case In Cleveland Dismissed

The five-year-old suit by the Cleveland Academy of Medicine against the Hopkins Clinic was ended on February 12 with the intervention of Common Pleas Judge Daniel H. Wasserman.

Attorneys representing both sides, who for years were locked in dispute over the alleged corporate practice of medicine by the clinic, agreed to a dismissal of the litigation.

Judge Wasserman, authorized by litigants to make the only statement, said:

"As a result of death of family members the operations of the Hopkins Clinic are being so altered that the legal questions in the case have disappeared."

The question at issue, namely the corporate practice of medicine remains unanswered.

The dispute arose from the clinic's offering of medical services by doctors who worked for the clinic under contract. The Academy contended this constituted corporate practice of medicine, which is forbidden under Ohio law.

Conference of County Society Officers . . .

Presidents, Secretaries and Certain Committeemen of Local Societies Meet in Columbus with Council Members; Excellent Turnout Is Recorded

SUNDAY, February 22, was a busy day in Columbus for key persons in County Medical Societies throughout the State. It was the Conference of County Medical Society Officers that drew together approximately 185 persons, and aired the latest developments on questions of vital interest to the medical profession.

Distinguished guest for the occasion was Dr. Julian P. Price, vice-chairman of the AMA Board of Trustees, who discussed "The Washington Scene," reviewed what is in the mill as far as health and medicine is concerned in the Nation's capital and urged that County Societies exert their influence on their respective Congressmen.

Leo Brown, director of the Division of Communications for the AMA, was another guest speaker who discussed the AMA's 1959 Public Relations program.

The State Association's legal counsel, Wayne E. Stichter, talked on the subject, "How County Societies Can Avoid Legal Pitfalls."

George H. Saville, director of public relations for the Ohio State Medical Association, reviewed and discussed legislation before the present session of the Ohio General Assembly.

To better discuss the several fields of interest of those present, the group was divided into

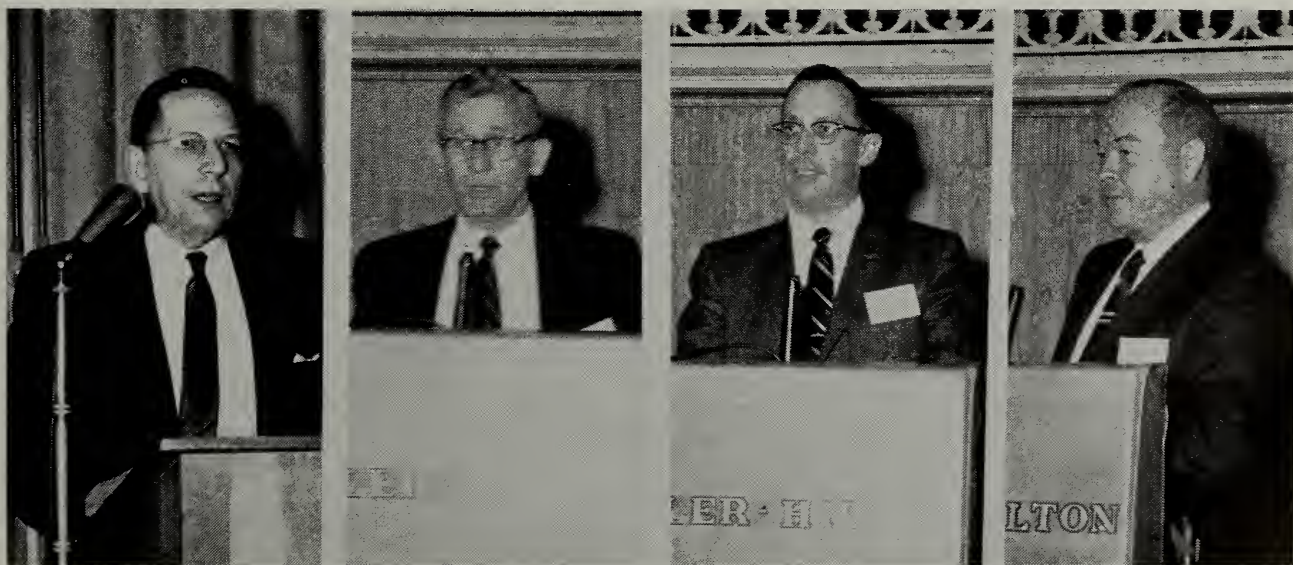
"How-To-Do-It Conferences." Those invited to attend were presidents and secretaries of County Medical Societies, chairmen of Legislative committees and chairmen of Public Relations committees. Respective group discussion meetings were held for each of these groups.

Under the subject of how-to-do-it for legislative chairmen, the program was led by Dr. John A. Fraser, chairman of the OSMA Committee on Legislation; Dr. Fred W. Dixon, chairman of the Committee on Federal Legislation; Dr. Price and Mr. Saville.

In the group discussion on how-to-do-it for public relations chairmen were the following leaders: Dr. Frederick P. Osgood, chairman of the OSMA Committee on Public Relations and Economics; Mr. Brown and Hart F. Page, assistant director of public relations for the OSMA.

In the discussion period on how-to-do-it for presidents and secretaries the following persons led the discussion: Dr. George A. Woodhouse, OSMA President; Dr. Frank H. Mayfield, OSMA President-Elect; Charles S. Nelson, Executive Secretary of the OSMA, and Mr. Stichter.

Another highlight of the day's events was the group of Councilor District conferences. This period provided an opportunity for each Councilor



Some of the principal Conference leaders are shown here: left to right: Dr. George A. Woodhouse, President of the Association; Dr. Julian P. Price, Vice-Chairman, AMA Board of Trustees; Leo Brown, AMA Public Relations Director, and Dr. Frank H. Mayfield, OSMA President-Elect.

District Groups Confer with Councilors



This is the First Councilor District conference. Presiding at this group meeting, out of camera range, was Dr. Charles W. Hoyt, Cincinnati, First District Councilor.



This excellent turnout is from the Second Councilor District. Presiding, but not shown here, was Dr. R. Dean Dooley, Dayton, Second District Councilor.



This is the group from the Third District with Councilor, Dr. Floyd M. Elliott (extreme right) presiding.

Where County Medical Society Officers Meet



This scene is in the Main Ballroom and shows some of the 185 persons who turned out for the conference. At the speaker's rostrum is Wayne E. Stichter, OSMA legal counsel.

to get together with those from his district and to discuss matters of local interest.

The conference was held in the Deshler Hilton where a complementary luncheon was served. The program concluded with a question and answer period, presided over by Dr. Mayfield with questions answered by all those who participated in the program.

Roster of Those Present

Those registered at the conference included the following:

OFFICERS AND COUNCILORS: George A. Woodhouse, Pleasant Hill, President; Frank H. Mayfield, Cincinnati, President-Elect; Robert S. Martin, Zanesville, Past-President; First District Councilor, Charles W. Hoyt, Hamilton; Second District, R. Dean Dooley, Dayton; Third District, Floyd M. Elliott, Ada; Fourth District, Paul F. Orr, Perrysburg; Fifth District, George W. Petznick, Shaker Heights; Sixth District, C. A. Gustafson, Youngstown; Seventh District, Robert E. Hopkins, Coshocton; Eighth District, William D. Monger, Lancaster; Ninth District, C. L. Pitcher, Portsmouth; Tenth District, Edwin H. Artman, Chillicothe; Eleventh District, H. T. Pease, Wadsworth.

FIRST DISTRICT: Adams County—Alexander Salamon, Seaman; Butler County—Clyde G. Chamberlin, Hamilton; James L. Sawyer and Robert A. Tennant, Middletown; Clermont County—Carl A. Minning, Batavia; Hamilton County—J.

Robert Hudson, Carl J. Ochs, Clyde S. Roof, Charles A. Sebastian and Mr. Edward F. Willenborg, all of Cincinnati; Highland County—J. Martin Byers, Greenfield; Warren County—Thomas E. Fox, Mason.

SECOND DISTRICT: Champaign County—John R. Polsley, North Lewisburg; Theodore E. Richards, Urbana; Clark County—Edwin E. Ash, John A. Davidson and Ray M. Turner, all of Springfield; Darke County—E. W. Arnold and Maurice M. Kane, Greenville; Jesse L. Heise, Pitsburg; Greene County—R. D. Hendrickson, Xenia; Paul C. Vernier, Fairborn; Miami County—J. E. Bausman, John W. Gallagher, W. W. Trostel, William W. Weis and Gerard F. Wolf, all of Piqua; Montgomery County—A. J. Carlson, Philip A. Eckert, Ward McCally, Charles E. O'Brien, Merrill D. Prugh, N. F. Stambaugh, Mr. Robert F. Freeman and Mr. K. C. Evans, all of Dayton; Preble County—E. P. Trittschuh, Lewisburg.

THIRD DISTRICT: Allen County—Thomas D. Allison, D. L. Steiner, Roger L. Tecklenberg, and Carl H. Zinsmeister, all of Lima; Auglaize County—Michael Rabe, New Bremen; Crawford County—Donald R. Wenner, Bucyrus; Hardin County—J. C. Lindsey, Kenton; Marion County—Thomas N. Quilter, Marion; Van Wert County—Jack H. Cox and Ralph E. Rasor, Jr., Van Wert.

FOURTH DISTRICT: Henry County—Thomas F. Tabler, Holgate; E. C. Winzeler,

(Text Continued on Page 536)

Here are More Councilor District Conferences



Fourth District Conference is shown. Dr. Paul F. Orr, Councilor for the District, presided at the meeting.



Dr. George W. Petznick (extreme right) Cleveland, Councilor of the Fifth District, presides at conference of District.

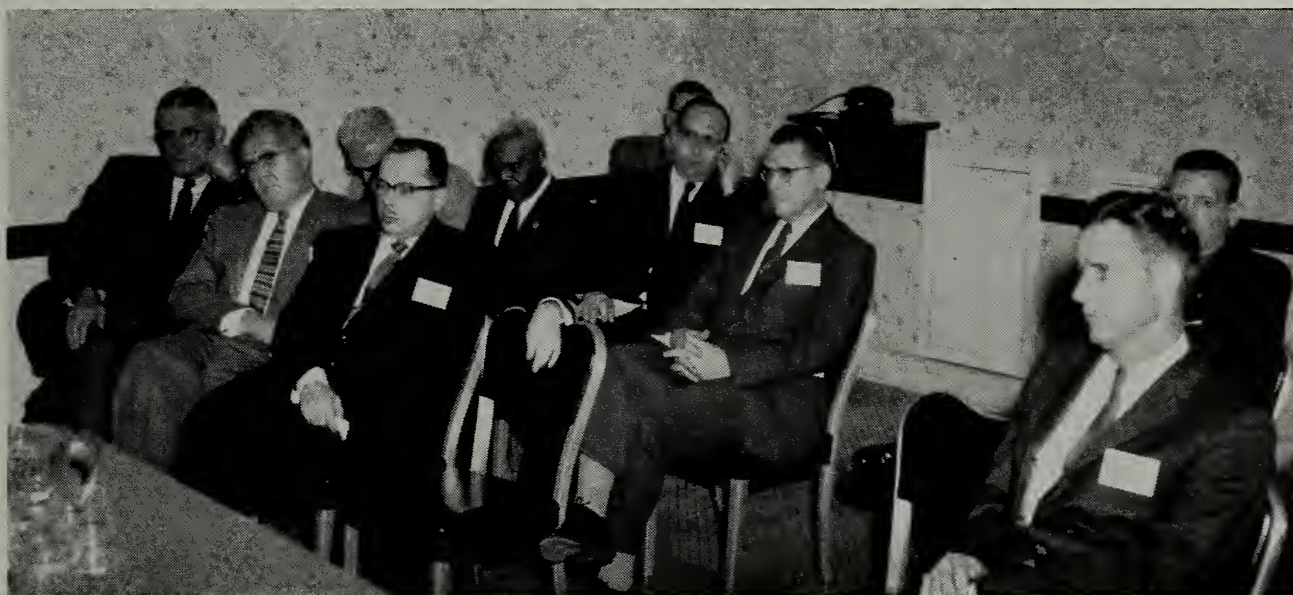


This is the group from the Sixth Councilor District with Councilor, Dr. Carl A. Gustafson, Youngstown, standing. All Counties of the District were represented.

Talking Over the Local Situation



The Seventh District meeting was presided over by Dr. Robert E. Hopkins, Coshocton, not shown in the picture.



Dr. William D. Monger, Lancaster, out of camera range here, presided over this meeting of the Eighth Councilor District.



Ninth District group gets together here with Councilor, Dr. C. L. Pitcher (in dark suit).

Tenth and Eleventh Districts Shown Here



Here are men from the Tenth District. Facing the same direction as the camera and therefore not shown, was Dr. Edwin H. Artman, Chillicothe, District Councilor.



All County Medical Societies of the Eleventh District were represented in this meeting, over which Councilor, Dr. H. T. Pease, Wadsworth, (not shown) presided.

Napoleon; Lucas County—A. A. Brindley, Maumee; H. F. Howe, C. W. McNamara, Frank F. A. Rawling, Maurice A. Schnitker, and Mr. Robert W. Elwell, all of Toledo; Putnam County—D. B. Lucas, Columbus Grove; Sandusky County—R. Allen Eyestone, Gibsonburg; Williams County—E. K. Bell, Bryan; Wood County—Robert C. Markey, R. L. Pearse and Stewart J. Smith, all of Bowling Green.

FIFTH DISTRICT: Ashtabula County—J. Jason Dixon, Ashtabula; Lewis H. Roth, Geneva; Cuyahoga County—Fred W. Dixon, Charles L.

Hudson, C. R. Jablonoski, Mr. Robert A. Lang and Mr. Don Mortimer, all of Cleveland.

SIXTH DISTRICT: Columbiana County—John A. Fraser, East Liverpool; William A. Kolozsi, Salem; L. S. Pritchard, Columbiana; Mahoning County—Lewis S. Shensa and Mr. Howard C. Rempes, Youngstown; Portage County—L. Fred Bissell, Aurora; Donald P. Van Dyke, Kent; E. A. Webb and Charles C. Whitsett, Ravenna; Stark County—A. E. Boyles, Louisville; Gervis Brady, Robert K. Gardner, John R. Seesholtz and Mr. E. M. Sprunger, all of Canton;

Two of the How-To-Do-It Conferences



This is one of the three how-to-do-it conferences—the one concerned with legislative matters. Another conference in the Ballroom was a discussion on matters of primary interest to presidents and secretaries.



This conference was planned for public relations chairmen and others with primary interests in public relations.

Summit County—Millard C. Beyer, Thomas S. Brownell, T. V. Gerlinger and Mr. Sidney H. Mountcastle, all of Akron; **Trumbull County**—James W. Loney, Clyde W. Muter, A. F. Nelson and Paul E. Noonan, all of Warren.

SEVENTH DISTRICT: Belmont County — John A. Brown, Morristown; D. Danenberg, Bridgeport; Benj. C. Diefenbach, Martins Ferry; **Jefferson County**—Ernest L. Perri, Steubenville; **Tuscarawas County**—Jay W. Calhoon, Uhrichsville; Philip T. Doughten, New Philadelphia; C. A. Bennett, J. W. Hamilton and George D. Woodward, Dover.

EIGHTH DISTRICT: Athens County—J. L. Webb, Nelsonville; **Fairfield County** — H. M. Amstutz, L. L. Kersell and Arthur B. Van Gundy, Lancaster; **Guernsey County**—William L. Denny and Jesse B. Kellum, Cambridge; **Licking County** —A. S. Burton, Kurt J. Fleisch, Raymond G.

Plummer and Jay R. Wells, all of Newark; **Muskingum County**—J. Herbert Bain, New Concord; Walter B. Devine and William A. Knapp, Zanesville; **Perry County**—O. D. Ball, New Lexington; Charles E. Bope, Somerset.

NINTH DISTRICT: Gallia County—Thomas W. Morgan, Gallipolis; **Hocking County**—George B. Watson, Adelphi; **Lawrence County**—George N. Spears, Ironton; **Pike County**—Paul H. Jones, Stockdale.

TENTH DISTRICT: Delaware County—Edward C. Jenkins, Delaware; M. W. Livingston, Sunbury; Lloyd E. Moore (Magnetic Springs); **Fayette County**—Robert A. Heiny and Hugh W. Payton, Washington C. H.; **Franklin County**—Perry R. Ayres, Ralph E. Dwork, James L. Henry, Richard L. Meiling, H. M. Platter, C. C. Sherburne and Mr. William Webb, all of Columbus; **Knox County**—Henry T. Lapp and James C. Mc-

Larnan, Mt. Vernon; **Pickaway County**—Edward L. Montgomery and H. H. Swope, Circleville; **Ross County**—W. M. Garrett, Robert E. Quinn and G. Howard Wood, Chillicothe; **Union County**—Paul R. Zaugg, Marysville.

ELEVENTH DISTRICT: **Ashland County** — Wayne C. Smith, Ashland; **Erie County**—Edward Gillette, Jr., Harry L. Hoffman, Richard F. Hoffman, D. R. Lehrer and Emil J. Meckstroth, all of Sandusky; **Holmes County** — N. P. Stauffer, Millersburg; **Huron County**—N. M. Camardese, Norwalk; **Lorain County**—Paul J. Kopsch, Denis A. Radefeld, Lorain; Harold E. McDonald, L. C. Meredith, Ben V. Myers and Mrs. Ruth Zealley, all of Elyria; G. K. Wiseman, Amherst; **Medina County**—William G. Halley, Lodi; R. L. Mansell, Medina; Nevin J. M. Klotz and Louis S. Zwick, Wadsworth; **Richland County**—Charles R. Keller and Harry Wain, Mansfield; **Wayne County**—R. I. Cottle and William R. Schultz, Wooster.

OTHERS: Julian P. Price, Florence, S. C., vice-chairman of the AMA Board of Trustees; Mr. Leo Brown, director of public relations for the AMA; Mr. M. L. Meadors, Florence, S. C., executive secretary of the South Carolina Medical Association; Mr. Wayne E. Stichter, legal counsel for OSMA; and Messrs. Nelson, Saville, Page, Edgar and Moore of the OSMA Headquarters Office.

Northern Tri-State Medical Group To Present Program May 7

The 86th Annual Meeting of the Northern Tri-State Medical Association will be held at the Schuler Hotel, Marshall, Michigan, on Thursday, May 7. The organization is composed of physicians in the neighboring areas of Ohio, Indiana and Michigan.

Registration fee is \$5 and reservations for the luncheon are \$5 per person. Registration should be sent to: Francis E. Elliott, M. D., Secretary-Treasurer, 130 North Fulton St., Wauseon, Ohio. Hotel reservations should be made direct. Rooms have been set aside for this purpose at the Schuler Hotel and Howard's Hotel, Marshall, Mich.

Provisions have been made for the ladies who wish to accompany their husbands. A special entertainment feature has been scheduled for 2 p. m.

The program has been announced as follows:

8:00 Registration.

9:00 Welcome.

9:15 **Open Reduction, Primary and Secondary Fusions in Fractures of the Os Calcis**, Dr. Homer Stryker, Chief of Orthopedics, Bor-

Claims Under Medicare Program Should Be Submitted Promptly

An urgent request has come from the Office for Dependents' Medical Care in Washington (Medicare) that physicians submit their claims promptly after the completion of care. Delayed billings cause many problems for the government, the contractors, the dependent or sponsor and the physician, all of whom are interested in settling the matter of payment as soon as practicable.

It is emphasized that Medicare contracts call for payment to be made on the basis of "complete" claims. As soon as a claim is completed it should be processed. Any old claims should be processed without further delay.

gess Hospital, Kalamazoo, Michigan; Dr. Harold Meier, Councilor 3rd District, Member of Trauma Section, Health Center, Coldwater, Michigan.

- 10:00 **The Diagnosis and Treatment of Peripheral Vascular Disease of the Lower Extremities**, Dr. Emerick Szilagyi, Associate Surgeon, Division of General Surgery, Henry Ford Hospital, Detroit, Michigan.
- 10:45 **Investigation and Treatment of Recurrent Urinary Calculus Disease**, William C. Baum, M. D., Former Assistant Professor of Surgery (Urology), University of Michigan Medical School.
- 11:30 **Social Hour:** Courtesy of Northern Tri-State Medical Association.
- 12:00 **Luncheon: Address—Is Your Thinking Up To Date Regarding Religion**, Rev. Calvin Didier, The Presbyterian Church, LaPorte, Indiana. Short Business Meeting.
- 2:00 **Commercial Insurance Looks at Blue Cross**, R. L. Paddock, President, Time Insurance Company, Milwaukee, Wisconsin.
- 2:45 **Laboratory Aids in the Differential Diagnosis of Functional Gynecological Disorders**, Gardner M. Riley, Ph. D., Associate Professor of Obstetrics and Gynecology, University of Michigan Medical School. Author of new book "Gynecological Endocrinology."
- 3:30 **Chemotherapy of Leukemia and Lymphoma**, Dr. Frank Bethel, Professor Internal Medicine and Director, Simpson Memorial Institute for Medical Research, University of Michigan Medical School, Ann Arbor, Michigan.

School Health Committee . . .

Polio Immunizations, Athletic Injury Conferences, PTA Health Record, Health Educators' Conference Among Topics Considered at Meeting

THE Committee on School Health of the Ohio State Medical Association met at the OSMA Headquarters Office, Columbus, February 8. Secretary Page announced that two bills regarding poliomyelitis immunization as a prerequisite for school entrance in Ohio had been introduced in the 103rd Ohio General Assembly on Thursday, February 5, 1959.

Compulsory Polio Immunization

After discussing the principles involved as well as the details of the proposed legislation the Committee suggested to Council the following policy statement:

"That the Ohio State Medical Association take immediate steps to find ways and means of getting more children immunized against poliomyelitis and other communicable diseases which are prevented by vaccination and immunization procedures.

"That the following Committee statement which was approved by The Council April 19, 1955, and constitutes existing policy on school examinations and immunizations, is pertinent and is reaffirmed:

"'1. A check on immunizations immediately prior to the child's entry into school is recognized as a function of school health supervision. However, parents should have primary immunizations done at the appropriate time in infancy, and this should be stressed by the family's personal physician.

"'2. Each child should have necessary booster immunizations before entering school and thereafter as indicated.

"'3. Each child should have a medical examination adequate for his or her welfare, proper school adjustment and protection of public health prior to entering school, and periodically, or as indicated by special need, during his or her school career.

"'4. These examinations and immunizations should be done in the office of the family's personal physician whenever feasible.

"'5. The local board of education should be encouraged to adopt regulations to enable the school to meet its responsibility in accomplishing these objectives.'

"It is believed that the existing law on school immunization requirements, as outlined in Section

3313.67 of the Ohio General Code is adequate to carry out the intent of the proposed legislation, and it is recommended that such law be implemented and enforced by local boards of education. This section reads as follows:

Present Law

"The board of education of each city, exempted village, or local school district may make and enforce such rules and regulations to secure the vaccination and immunization of, and to prevent the spread of communicable diseases among the pupils attending or eligible to attend the schools of the district, as in its opinion the safety and interest of the public require. Boards of health, legislative authorities of municipal corporations, and boards of township trustees, on application of the board of education of the district, at the public expense, without delay, shall provide the means of vaccination and immunization to such pupils as are not provided therewith by their parents or guardians.'

"It is our opinion that the legislation proposed in Senate Bill 161 and House Bill 353 is unnecessary for the reasons stated above, and in addition, it is felt that local regulations, authorized under existing statutes are preferable to a Compulsory State Law, and that the specification of immunization procedures and dosage in the statutes is inadvisable, in that medical science is continuously changing."

(See Council minutes, Page 528 this issue, for approval OSMA policy on these proposals.)

PTA Health Record

Chairman Shaffer brought before the Committee a request from the Chairman of the Committee on Pre-School Health of the Ohio Congress of Parents and Teachers, that the health record form distributed by the PTA be reviewed. The educational value of such records was discussed, and members of the Committee studied records published by the American Medical Association and by the Committee on Rural Health of the Ohio State Medical Association. The Committee voted to approve the Ohio PTA Health Record Form as submitted, provided that the following changes are incorporated:

1. That the heading above physical examination on the inside front cover be changed, deleting the

words in parentheses "Physician and Dentist check each item," and insert in lieu thereof the words "Check Abnormal Findings only."

2. That under "Record of Immunizations" on the back cover, the recording of Diphtheria, Whooping Cough and Tetanus immunizations be combined under a single heading of Diphtheria-Pertussis-Tetanus immunization.

The Committee agreed also to recommend to Council that if the PTA so desires, the words "This record form approved by the Committee on School Health of the Ohio State Medical Association," may be printed on the record blank.

Athletic Injury Conferences

Dr. Shaffer announced that the Chairman and the Secretary had held several exploratory meetings with representatives of the Ohio High School Athletic Association with regard to joint sponsorship of Athletic Injury Conferences on a district, county, or local basis.

It was announced that Secretary Page had been authorized by The Council at its meeting of September 12-14 to appear before the District Boards and Board of Control of the Ohio Athletic Association to discuss such conferences and to offer OSMA cooperation. Mr. Page stated that he had complied with this authorization at the September 20 meeting of the OHSAA Boards.

Commissioner's Views

Commissioner McConnell was then introduced. He offered the cooperation of the OHSAA in the joint sponsorship of Athletic Injury Conferences. He suggested that three or four be held during the forthcoming year, that a maximum of five be held each year thereafter, and that they be moved around to cover different areas.

Mr. McConnell felt that the best time for the series would be right after football season, when football injuries are fresh in mind and when the coaches have more time for meetings. He listed areas wherein OHSAA members have signified readiness to go ahead with conferences of this type.

The programs offered by the Montgomery County Medical Society in Dayton were reviewed by Dr. Kagay.

The Committee expressed its appreciation to Commissioner McConnell and recommended that the Committee on School Health of the OSMA cooperate with the Ohio High School Athletic Association in setting up a series of conferences on Athletic Injuries as soon as the project is approved by The Council.

The Committee recommended that local medical societies be encouraged to make certain that a

member of the society be in attendance at all football games, either as school employee or volunteer, and that a member be available for service in emergencies which might develop in other athletic contests.

Health Educators Conference

It was reported to the Committee that the State Planning Committee for Health Education had voted, at the recommendation of its long range planning committee, to sponsor a conference for college and university health education administrators and teachers during the 1959-1960 year.

It was pointed out that the purpose of such a conference would be to provide sound medical orientation and authentic health materials to educators who are training health teachers for elementary and secondary schools.

The Committee voted to request The Council's permission to assist with such a conference and to give it reasonable financial support, in line with that offered by the other organizations.

The dates of the Sixth Ohio Conference on Physicians and Schools, May 5, 6, and 7, were announced and members of the Committee were urged by the Chairman to attend for at least a part of the session.

Disease Directory

Copy for a proposed "Disease Information Directory" for school teachers was submitted by the Ohio Department of Health for review by the Committee. The members of the Committee considered the copy and were of the opinion that it was too comprehensive and too technical for the purposes for which it was designed. They expressed willingness to review a simplified version of the copy if such is submitted to them.

Organization Seeks To Bring Together Doctors Interested in Art

Efforts are being made to stimulate additional interest among Ohio physicians in the American Physicians Art Association. Thomas E. Newell, M. D., 1315 Bryn Mawr Drive, Dayton 7, has invited interested Ohio doctors to contact him. He is first vice-president of the national organization.

The APAA has held 21 annual art exhibitions to date. The exhibitions have become an integral part of the annual AMA conventions. To further the art interest among physicians, APAA also issues descriptive catalogues, newsletters, and stimulates local cultural meetings for physicians to exchange views and ideas in the field of art.

Membership includes those in the fields of painting, sculpture, photography, graphic arts, design and creative crafts. Additional information may be obtained by writing Dr. Newell.

Governor's Health Message . . .

Recommendations for Immediate and Future Projects To Be Undertaken By State Administration Made in Message to Legislature by Gov. DiSalle

GOVERNOR MICHAEL V. DISALLE presented a special message on public health to the Ohio General Assembly on February 18. It was the first time in many years that a chief executive has sent a special message on health to the State Legislature. Text of the message follows:

"Protection of public health is a major responsibility of government. The people of Ohio have a right to expect that their state government will take every possible step to guard them against the spread of infectious diseases and against other hazards to health.

"Adequate legislation and financing are essential to the development of statewide public health programs which will meet today's changing needs. With this in mind, I wish to call your special attention to certain legislative proposals in the field of public health.

"As I said in my State of the State Message, the legislative program of the State Department of Health is a reasonable and a modest one. I believe it will merit your support.

"One of the bills is aimed at protecting the public against the hazards of radiation from nuclear sources. Rapidly increasing peacetime use of atomic energy, combined with a growing understanding of risks in previously existing and used radiation sources, presents a compelling argument for this legislation.

"This bill places responsibility for protection in the Health Department, but it does not preclude or run contrary to the existence of any other state agency concerned with promotional and commercial aspects of radiation.

"The bill makes provision for registration of radiation sources, for adoption of necessary regulations for proper shielding and other protective measures, for inspection and for the issuance when necessary of orders to prohibit, modify, control or abate improper radiation. It provides for an advisory board that would include the heads of other interested departments of the state government and appointive members with special knowledge and experience in the field of radiation. This is needed legislation.

"Public health programs in a state such as Ohio are carried out to a large extent by local health departments with the guidance, assistance and

support of the State Health Department. It is essential, therefore, that local health departments be strong, and it is obvious that they must be strong in our less populated districts as well as in the areas of dense population.

Merging of Departments

"One of the methods of strengthening health programs in rural areas has been by the merging of city and county health departments where feasible. You have for consideration a bill to amend existing legislation relative to the combination of boards of health. The proposed new law should make such combination easier to accomplish.

"Ohio has a particularly black mark against it with respect to rabies. Two Ohio children died from this horrible disease last year, and many other persons had to take the long series of protective shots after exposure. In 1957, the last year for which comparable figures are available, only four states had more reported cases of animal rabies than Ohio.

"A bill is being presented which would give the director of health authority to declare problem or epidemic areas in which immunization of dogs against rabies would then become a requirement before the dogs could be licensed. This is reasonable. In Ohio 65 per cent of all animal rabies cases for a three-year period (1955-1956-1957) occurred in three counties.

Proposed Division of Alcoholism

"Next I should like to call your attention to a bill which would create a Division of Alcoholism in the Department of Health. This bill actually has been presented by and is being supported by several local councils on alcoholism from some of the larger Ohio cities. These councils are broadly representative in nature, including the judiciary, clergy, private medicine, public health, industry and welfare, all of which have recognized alcoholism as a growing problem. They estimate that Ohio has over 200,000 alcoholics.

"The legislation provides that the program of the proposed Division of Alcoholism would include research, education, and consultation with other agencies (state and local, public and private) in the development of treatment and rehabilitation work, utilizing existing resources wherever possible. Budgetwise this would be a

minimal program. In results it could be of maximum significance.

"You will receive two bills with respect to operation of the Ohio tuberculosis hospitals. Both of these are to clear up technicalities. One would permit a probate judge, at his own discretion, to hold a hearing in the hospital rather than in his court for a patient in the recalcitrant unit of the hospital. The other would legalize a small welfare fund, obtained from the profits of a commissary, to purchase necessary items for needy patients, such as eyeglasses and dentures which are not provided for in other funds.

"Two other bills will be introduced to bring the registration of vital records in Ohio in conformity with national registration standards and practices and to simplify reporting procedures.

Air and Water Pollution

"It is my strong conviction, previously stated to you, that the state must pursue aggressive programs for the prevention and abatement of water pollution and air pollution. We have, on the statute books, a law for water pollution control which seems to be adequate. Considerable accomplishment in the construction of municipal sewage treatment plants and industrial waste treatment facilities has been made in the last few years. It will be my purpose to press for the strict enforcement of this law against any laggards.

"This, of course, will be largely a matter of strong administrative procedures rather than reliance on additional legislation. My concern with respect to the water pollution control law is to resist any attempts to weaken it.

"At every session of the General Assembly since this law was passed in 1951, some attempts have been made to limit and circumscribe this law. These attempts have been defeated. I have no doubt that this session of the General Assembly will also resist similar attacks.

Funds Not Appropriated

"As far as air pollution is concerned, the last session of the General Assembly enacted legislation for the establishment of a laboratory and research program on air pollution in the State Department of Health and to provide for the development of programs and consultation with political subdivisions in the control of atmospheric pollution. However, no funds were appropriated for this purpose. The laboratory has not been established. The program has not been developed.

"Equipment needed for this work is very costly, virtually prohibitive for all but the largest cities. This makes it logical to provide one central lab-

oratory and staff to serve all municipalities. Regulation and enforcement are a responsibility of local government, with technical assistance and guidance from the state.

"Vast quantities of wastes of all kinds are being thrown into the atmosphere above our cities. There they intermingle and interact chemically, catalyzed by sunlight. Millions of urban and suburban dwellers breathe in the mixture. Although the study of health effects of air pollution is in its infancy, we already have knowledge of many dangers involved. We have reason to suspect that polluted air may have long-term effects on our health surpassing in importance anything we yet can prove.

It would be well for the General Assembly first to pass legislation enabling local governments along the borders of our state to enter into agreements with other states and communities along the borders of those states with reference to mutual assistance in attempting to control the sources of this pollution.

Limits of Budget

"The part the state must play eventually, in research and in the establishment of a laboratory, will have to be guided largely on the basis of the availability of finances. This will have to await our review of the budget and the message which will carry our recommendations with reference to that all-important commodity.

"When a unit of government is faced with a shortage of funds, it must attempt to take care of its needs on the basis of priority. Highest on the list of priorities must be those programs already initiated but which are not fulfilling their intended purpose as a result of understaffing or underfinancing. After those needs then must come those important programs which must be placed in the category of needed, but the inception of which must await the necessary financial means.

Labeling Law

"In addition to the laboratory and research program on air pollution, in this classification we find a program of labeling hazardous substances of household products.

"There is a very obvious need in the public health field for legislation which would require the adequate labeling of hazardous substances used in households, or used in schools, hospitals, apartments, hotels, and restaurants.

"Thousands of such substances are now in commercial trade for household and institutional use with neither warning as to potential danger nor identification of contents which might assist

in quick diagnosis and proper treatment after exposure.

"Dramatic evidence of the need for such labeling is shown in admissions to hospitals throughout the state of children and adults who have ingested or otherwise been affected by household products containing toxic chemicals.

"The Department of Health has developed a planned budget necessary to make legislation in this area effective. If laboratory equipment is provided for an air pollution laboratory, then the cost of equipment necessary for the labeling program will be \$45,000 less. If the air pollution laboratory should not be established, then the estimated first-year cost of the labeling program would be \$175,000 instead of \$130,000. This is exclusive of space cost.

Inspection of Meat

"A third program which might be considered as needed is the program of state inspection of meats slaughtered in noninspected facilities at this time. Here again, the question of state subsidy for this program has ruled against its inclusion.

"This again raises the question as to whether or not it is completely the obligation of the state to pay for a service which, in its nature, is required as a protection to the public. Yet, as a result of state inspection, meats now slaughtered in noninspected facilities would obtain new markets and produce new values to the slaughterer and the packer.

"Consequently, there would be some justification in having the cost of this service paid in the form of fees which would be completely self-supporting as far as the program is concerned.

"I doubt that this would be considered desirable on the part of the slaughterers and packers, but I submit it to you as a possibility, feeling that at this time the state cannot afford to add another expenditure of funds for a new program, when its existing programs in some cases are under-financed.

A Matter of Priority

"This message, of necessity, has fallen into three parts—those measures which we definitely recommend for adoption since they are largely corrective in nature, some enabling, and one or two with very small additional costs.

"The second category of measures are those with high priority and desirable, if finances are available, and the third those measures which are desirable and even necessary but which we cannot consider at this time since there seems to be very little possibility that money will be available for them.

"One might ask why discuss the measures in

the third category. It has been my experience that worthy objectives are often accomplished only after a great deal of discussion and a great deal of thought. They are deferred, but as discussion begins to affirm the necessity of these programs, eventually they become a part of the overall program in which government engages for the protection of the health, safety, and welfare of its citizens.

"It is my further feeling that the Legislature should always have before it, as completely as possible, the entire thinking of the executive branch of government, that thought which impels the recommendation of some programs and which makes necessary the denial of others."

—Michael V. DiSalle,
Governor.

February 18, 1959

President Approves New VA Bed Policy

President Eisenhower has given his approval to a new Veterans Administration hospital bed policy. It includes:

1. The President sets a 125,000 authorized bed capacity in VA installations, for service-connected cases and for non-service-connected cases unable to defray expenses and where beds are available. Ratio today is about 60 per cent non-service-connected and 40 per cent service-connected. Mr. Whittier says the gap in these percentages will continue to widen because service-connected load will decline.

2. Greater flexibility in locating beds where need is greatest. In other words, the administrator can shut down a hospital for lack of patients or inability to recruit personnel, and have them transferred to another facility.

3. Authority to shift utilization of beds, say from tuberculosis to neuropsychiatric cases. In 1950 VA had 16,195 TB beds in operation; last year this had declined to 10,250.

Akron EENT Group To Present Program On Aspects of Allergy, May 4-6

The Akron Academy of Ophthalmology and Otolaryngology has announced a Postgraduate Course in Allergy and the Endocrinological Aspects of Allergy at the Akron City Club, Ohio Building, Monday-Wednesday, May 4-6.

Guest speakers will be Dr. Herbert J. Rinkel, Kansas City, Mo., and Dr. Z. Z. Godlowski, associate in medicine at Northwestern University, Chicago. AAGP credit will be given if desired.

Registration fee is \$35. For further information contact: A. L. Peter, M.D., 656 West Market Street, Akron 3, Ohio.

Traffic Safety . . .

OSMA Committee Distributes Suggested Guides on Medical Aspects Of Problem to County Societies; Other Activities also are Considered

DEVELOPMENT of more awareness of and interest in medicine's role in traffic safety throughout Ohio is expected to follow distribution of a traffic safety handbook to local medical societies.

Prepared by OSMA's Traffic Safety Committee, and approved by The Council on February 21, the handbook, "Traffic Safety Guides for County Medical Society Committees," is accompanied by considerable resource material. Purpose of the handbook and accompanying material is to help local medical society traffic safety committees blueprint immediate and long-range programs.

Also approved by The Council on February 21 was the committee's recommendation that OSMA request the Ohio Department of Highway Safety and the Bureau of Motor Vehicles to consider placing on the Ohio driver's license form space for the driver to enter his blood type and his most recent tetanus toxoid immunization, on a voluntary basis.

Serves Dual Purpose

Purpose of this move would be to provide immediate medical information in accidents, and to help make the driver aware of the medical aspects of traffic safety, and its implications.

The committee will have an exhibit on physician responsibility in traffic injuries at the OSMA Annual Meeting in Columbus April 21-24, and an exhibit concerning alcohol and the drinking driver at the Cincinnati Academy of Medicine's Traffic Safety Public Meeting, May 2-5.

The committee plans to arrange a meeting in the near future with Department of Education and Department of Highway Safety officials to discuss mutual questions, including review of physical standards for driver's license applicants, visual and general physical examinations of school bus drivers and physical examinations for repeated traffic offenders.

The committee also plans to explore the possibility of meeting with officials of power boat squadrons of Ohio to review medical and health questions involving safety programs affecting those owning or operating water vehicles.

Study Emergency Manual

Members of the committee currently are reviewing an advanced "Emergency Rescue Squad Man-

ual" prepared and distributed through the Ohio Division of Vocational Education, with the assistance of the College of Education, Ohio State University.

At a February 15 committee meeting, Mr. Jack B. Liberator, R. N., coordinator of emergency and rescue squad training, OSU Trade and Industrial Education Services, appeared to request OSMA approval of the manual.

Mr. Liberator presented, with respect to training available to squadmen in Ohio, the following five points:

First Aid. Standard, Advanced, and/or Instructor Courses. There are many groups and agencies who teach first aid and are available at all times. All squadmen must have at least Standard or Advanced First Aid Training to participate in squad work.

Regional Fire Schools. These are sponsored by the local county associations and are usually held over a weekend. These schools are very helpful and those interested in squad work should enroll in the Squad section of the Regional Schools. The Fire Department Training Service of Trade & Industrial Education provides staff and usually cooperates financially in the instructional program of these schools.

Emergency Squad Course (40 hours). This course is sponsored by the State Trade & Industrial Education Service and covers many different areas of victim care and rescue procedures needed by squadmen which are not taught by any other agency. First Aid cards are necessary as this course builds on top of first aid work.

Emergency Room Training Program. To supplement the 40-hour course, the state Coordinator of Emergency and Rescue Squad Training will help establish, where possible, an organized program for experience in a local hospital emergency room. This experience will help the squadman appreciate the value of his work and how it carries over into the emergency room situation. A number of hospitals have already expressed a willingness to cooperate in this plan.

Ohio State Fire Schools. Sponsored by the Ohio State Fire Marshal's office, in cooperation with Trade & Industrial Education Services, it is a one-week, concentrated course of study for all interested and experienced firemen of the state. In this school there are usually five areas of in-

Two Workmen's Compensation Medical Report Blanks Revised To Simplify and Expedite Handling by Physicians

JAMES L. YOUNG, Administrator, Bureau of Workmen's Compensation, has announced the revision of two of the Bureau's forms of interest to Ohio physicians.

On the application for medical benefits only (Form C-3, pink), where there is less than seven days lost time, the Bureau has simplified the attending physician's report by reducing the number of items from nine to five. Also, the space for answers has been enlarged to accommodate handwriting or double-space typing.

The application for compensation and medical benefits (Form C-1, blue) has been revised to make the employer's report simpler. Concurrently, the Bureau has revised the Form C-1a, which is the attending physician's report.

The Bureau has been accepting the claimant's application and the employer's report, securing the physician's report later. The procedure was to send the physician's report to the claimant who then took it to the physician for completion.

Effective March 1, 1959, the Bureau now sends the revised physician's report directly to the physician.

This new form C-1a is green in color and consists of a shortened and simplified report for the physician and a fee bill for services rendered to date. The form is in triplicate and one copy may be retained by the physician. The other two copies are to be sent to the nearest District Office. One will then be placed in the file and the other forwarded to the employer.

The inclusion of the fee bill in the C-1a form will eliminate paper work for the physician and the Bureau. If the physician indicates that further treatment is necessary, the Bureau will send him an additional fee bill.

The Bureau requests that existing stocks of blanks be used since 100,000 C-3 forms are distributed each month and only 20,000 such claims are filed.

Ohio's physicians are reminded to include their medical license number on all fee bill reports in order to expedite the payment of fees.

struction, one of which may be planned for Emergency and Rescue Squads. This school provides high level instruction in specialized areas to the squadmen of the state of Ohio.

The committee will make a recommendation to The Council concerning the requested OSMA approval after completing its review of the manual.

In keeping with its policy of maintaining state level liaison with other traffic safety groups, the committee and OSMA were represented by Dr. Tom F. Lewis, Columbus, at a meeting of the Legislative Committee of the Governor's Traffic Safety Committee, January 6, and by Dr. Drew L. Davies at a meeting of that committee's Education Committee, January 12.

Judge Reverses Jury in Noted 'Sodium Amytol Case'

The much-publicized "sodium amytol case" in Columbus involving suit of John W. Freeman against the New York Central Railroad Company for personal injury damages, ended with the judge

reversing the jury and finding for the defendant. An appeal is pending.

The case involved John W. Freeman, Columbus, who was struck by a train in 1954, suffering loss of both legs and spinal injury. Freeman had asked \$250,000 and the jury awarded him \$38,345. However, in a finding March 2, Common Pleas Judge Joseph M. Harter reversed the jury and found for the defendant NYC on grounds of contributory negligence and trespass on the part of the plaintiff.

The case drew widespread newspaper and national news magazine publicity when testimony was presented that the plaintiff's memory of happenings immediately before and after the accident was stimulated through use of sodium amytol.

In his ruling, Judge Harter stated that "the evidence relating to treatment (of the patient) with sodium amytol was, relatively, the least important aspect of this case."

One of the attorneys for the plaintiff was Melvin M. Belli, of San Francisco, California, much-publicized attorney for plaintiffs in personal injury suits.

Licenses Granted . . .

State Medical Board as a Result of Recent Examinations Authorizes Fifty Graduates of Medical Schools To Practice Medicine in Ohio

RESULTS of the examinations conducted by the State Medical Board of Ohio December 16-18, 1958, were considered by the Board at its meetings on February 3. Fifty graduates of schools of medicine were authorized to receive certificates to practice medicine and surgery in the State, Dr. H. M. Platter, secretary of the Board, reported. In addition, 32 graduates of osteopathic schools were authorized certificates to practice osteopathic medicine and surgery.

In the limited practice branches, certificates were issued to two chiropodists, one mechanotherapist, eight chiropractors, two masseurs and four cosmetic therapists.

Highest grade in the examinations for doctors of medicine was made by Joan H. Shalack, Akron, a graduate of the Woman's Medical College of Pennsylvania.

Following is the list of those licensed to practice medicine and surgery. (Home address is given in parentheses if the home address is different from the place of residence at time of examination.)

Graduates of U. S. and Canadian Schools

Matthew B. Ganz, Akron (Cleveland Heights), Ohio State University; Osbie J. Herald, Columbus, Ohio State University; John B. Hodges, Jr., Rochester, N. Y. (Cleveland), Western Reserve University;

Clarence J. Kluck, Columbus, University of Wisconsin; Leonard Levine, Cleveland Heights (Winnipeg, Canada), University of Manitoba, Canada; Frederic T. Mauck, Cincinnati (Port Kennedy, Pa.), University of Pennsylvania; Donald J. Norton, Cincinnati (Toledo), University of Cincinnati; Elijah L. Polk, Cleveland, Meharry University; Sarah Stephens Polt, Leavittsburg, Woman's Medical College of Pennsylvania;

Joseph R. Poole, Columbus (Minford), College of Medical Evangelists; George Potor, Jr., Columbus (Campbell), Ohio State University; William D. Reed, Waynesburg, Pa., Temple University; Hal R. Rhynearson, Springfield (Anderson, Ind.), Indiana University;

Oliver L. Richards, Jr., Detroit, Mich. (Salt Lake City, Utah), University of Utah; Joan H.

Shalack, Akron, Woman's Medical College of Pennsylvania.

Graduates of Foreign Schools

(Arranged alphabetically by country in which medical school of graduation is located.)

Austria: University of Graz—John Spur, Cleveland (Yugoslavia).

University of Innsbruck—Dimitri C. Bouhoutsos, Toledo; Dimitri Krajewsky, Lima.

University of Vienna—Philip Goldberg, Dayton (New York City).

Cuba: University of Havana—Guillermo P. Herrera, Dayton.

France: University of Paris—John H. Hirschberg, Greystone Park, N. J.

W. Germany: University of Bonn—Orest M. Ryzij, Chagrin Falls.

Germany: University of Erlangen—Myra I. Snylyk, Dixon, Ill.

University of Freiburg—Marianne Schempp Hollander, Philadelphia, Pa.

University of Hamburg—Hans J. Klapproth, Cleveland; Irene M. Leszkiewicz, Cleveland; Steven Zsako, Cleveland.

University of Heidelberg—Eugene Martyniuk, Akron; Myroslaw Nawrockyj, Philadelphia (Ukraine); Ognjan Petroff, New York City; Frederick J. Richter, Cleveland.

University of Munich—Edward H. Kirsch, Keshena, Wisc.; Georg Russanow, Oak Park, Mich.

Hungary: University of Szeged—Bela Karoly Der, Forest Hills, L. I., N. Y.

Ireland: Apothecaries Hall, Dublin—Charles H. Norchi, Jr. (Youngstown).

Italy: University of Rome—Benedetto Valente, Cleveland.

University of Turin—Eugene A. Capocasale, Columbus.

Latvia: University of Latvia—Janis Urjanis, Pownal, Maine.

Lebanon: American University of Beirut—Robert I. Zarzar, Lima.

Mexico: National University of Mexico—Sal-

vador Alatorre, Hamilton; Carlos A. Maldonado, Cleveland (Mexico).

University of Guadalajara—Enrique A. Lozano, Berea.

Netherlands: University of Leiden — Robert S. Tulchin, Cleveland (New York City).

Poland: University of Poznan—Walter Doktor, Berwyn, Ill.

University of Warsaw — Eugene Nargiello, Scotch Plains, N. J.

Portugal: University of Lisbon—Sergio M. DeCarvalho, Cleveland Heights (Lisbon).

Switzerland: University of Bern — William M. Pack, Newark, N. J.

University of Zurich—Dimitrios C. Catsaros, Elmhurst, L. I. (New York City).

Ukraine: University of Kiev — Lydia Tkacz-Stowbun, Akron.

Yugoslavia: University of Belgrade — Galina Hrushchov, Cleveland.

* * *

Licensed Through Endorsement by State Medical Board

The State Medical Board of Ohio has issued licenses to practice medicine and surgery in the State to the following physicians through endorsement of their licenses to practice in other states, or certification by the National Board of Medical Examiners (included are intended residence and medical school of graduation):

February 3—Carlos Alvarez, Chesapeake, Univ. of Mexico; Robert L. Atkinson, Cleveland, Univ. of Illinois; Thomas E. Bilon, Lima, Univ. of Nebraska; John S. Bradshaw, Cleveland, Harvard Medical School; Alan B. Cameron, Harvard Medical School; Javier Cano, Cleveland, Nat. Autonomous Univ. of Mexico; Joseph M. Caterini, Univ. of Naples; Ronald Chapnick, Cleveland, New York Univ.; Forrest W. Crocker, Akron, Univ. of Michigan;

Robert A. Daniel, Akron, Indiana University; Bernard Dolin, Dayton, Univ. of Lausanne; Stephen J. Galla, Cleveland, Johns Hopkins Univ.; Leonard Harris, Gallipolis, New York Univ.; Michel Janis, Univ. of Paris, France; Juan Llompart, Univ. of Madrid, Spain;

George Majnarich, Univ. of Naples, Italy; Marion Makohin, Cleveland, Univ. of Erlangen, Germany; Hendrik J. W. Marcella, Youngstown, State Univ. of Leiden, The Netherlands; Thomas L. Meyer, Jr., Columbus, Northwestern Univ.; Stanley M. Mitnick, Cincinnati, Hahnemann Medical College;

James C. Neely, Cincinnati, Columbia Univ.; John O'Carroll, Youngstown, Nat. Univ. of Ire-

land; Iwan Podrygula, Univ. of Prague, Czech.; Joseph G. Polusky, Cleveland, State Univ. of Leiden, Netherlands; Rhodes W. Quisenberry, Medical College of South Carolina;

Edmund Ringus, Univ. of Freiburg, Germany; Oleg P. Schidlowsky, Univ. of Munich, Germany; Lillian Singer, Cincinnati, Univ. of Prague, Czech.; Nick Stergen, Nat. Univ. of Athens, Greece; Kirwin H. Stief, Jefferson Medical School; Ralph A. Straffon, Cleveland, Univ. of Michigan;

Rose K. Wang, Youngstown, Cheeloo Univ., China; Charles A. Whitten, Jr., Youngstown, Univ. of Buffalo; Shao-Chen Yu, Tung-dee Med. College, China; Shao-Chi Yu, Nat. Sun Yat-Sen Univ., China.

OSU Mental Health Study

The Columbus Psychiatric Institute and Hospital on the campus of Ohio State University recently received a grant of \$300,000 for studies in the cause and treatment of schizophrenia from the National Institute of Mental Health, U. S. Public Health Service. Dr. Ralph Patterson, superintendent, announced that Dr. Benjamin Pasamanick, institute director of research and professor of psychiatry, will conduct the research with Dr. Roland Fischer, university research biochemist.



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Sources of Drugs . . .

From the Meat Processing Plants to the Native Divers of the South Pacific, the Drug Industry Gathers Products from a Thousand Sources

IN any discussion of drugs and medicines a distinction should be made between the production of the active ingredients (the specific chemicals and biologicals used in medicine) and the manufacture of pharmaceutical preparations—the dosage forms into which the drugs are formulated for ultimate use. This article is concerned with medicinal chemicals and biologicals in order to show their sources and how they are produced.

Medicinal Chemicals

The specific substances used in medicine are obtained from sources as diverse as the bark of a tropical tree (quinine), the liver of a deep-sea fish (vitamin A), and a carefully grown mold (penicillin). Most people never see drugs in their pure form, but think of them only as the tablets or liquids which are prepared for their use, and in terms of their effect in preventing an illness, altering its course, or relieving its symptoms.

The sources of the active ingredients are of considerable importance to the physician and his patient, however, from the standpoint of the quality of the product, the quantity of the substance available at any one time, and the cost of producing it.

Manufacturers are constantly searching for dependable methods of producing existing drugs by a simpler method and at a lower cost in order to obtain a competitive advantage in the market. As a result, many drugs can be produced today by more than one chemical process, or can be obtained from more than one source. Cortisone, for example, may be produced chemically by two or more methods or may be obtained through a fermentation process. Vitamin A, once obtained primarily from fish-liver oils, can also be made synthetically from basic chemicals.

Synthetic Organic Chemicals

Organic chemicals are those compounds which, like plant and animal matter, contain the very prevalent carbon atom linked together in a certain way. In essence, chemical synthesis is the process of building a more complex chemical out of relatively simple and inexpensive ones, by means of a series of carefully controlled chemical reactions. Starting with a few building blocks, called intermediates, thousands of different compounds can be scientifically created.

Of all the 102 known elements, carbon forms

Editorial Note:

The age-old principle of supply and demand has played a tremendous role in development of the drug industry and is maintaining a high level of quantity and quality never before imagined.

The patient is vitally interested in the supply and demand of drugs, but probably not in those terms. He may think of demand only in terms of his own needs and of supply in terms of availability at the corner drug store.

The accompanying article is presented in lay terms deliberately so the doctor may relay this information to his patients in their own language. This is the fourth in a series of articles that endeavors to set forth answers to some of the provocative questions being asked about the pharmaceutical industry, drug costs, research and the like. It is excerpted from a pamphlet entitled *Facts About Pharmacy and Pharmaceuticals*, published by the Health News Institute. Previous articles appeared in the January, February and March issues.

Since public relations begin in the doctor's office, many physicians will want to keep their patients up to date by answering questions about drugs—close allies to the medical profession.

the most compounds. For a long time it was believed that only live natural plant and animal products—in other words, products derived from things that were alive or had lived—were *organic* (containing carbon). All other materials—those which had never lived, such as salt, rocks, sand and other minerals, water and most gases—were classed as *inorganic* or nonliving.

Early scientists were amazed at the number of compounds containing carbon that they found in analyzing plant and animal tissue. But this is no mystery—it is explained by the unique ability of carbon to link up with itself and other chemical elements, such as hydrogen, nitrogen, oxygen, etc., to form more chains or rings than any other element. Starches, sugars, oils, fats and proteins of hundreds of different kinds—all containing carbon—are therefore organic.

In 1828, a German scientist, Friedrich Wohler,

discovered that carbon compounds could be made by chemically (in imitation of natural substances) combining carbon with inert or inorganic, never-living material. Following Wohler's synthesis of urea, a crystalline compound found in urine, other investigators began to build simple carbon-containing compounds—literally new substances, not previously found in nature. Today the technical handbooks list more than a half million organic compounds, many of them useful in medicine. Since they are man-made, they are called *synthetic* and far outnumber the naturally occurring compounds which have been identified.

By far the largest production of drugs today comes from chemical synthesis. In terms of quantity, acetylsalicylic acid (aspirin) is the most important. In 1956, a total of 16,603,000 pounds of aspirin were produced. Twelve billion 5-grain tablets alone were prepared from this.

Even when drugs can be obtained from natural sources, such as plants or animal products, research chemists are constantly searching for ways of producing them by synthetic means. Chemical synthesis is usually the desirable source of supply for several reasons:

1. Synthesis of organic chemicals from basic intermediates usually furnishes a more dependable source of supply.
2. Production through synthetic means usually results in a product with a higher degree of purity.
3. Production through synthesis can usually be achieved more economically.

Inorganic Chemicals

These are chemical compounds that do not contain carbon in the organic chemical linkage. They include the metals and their salts and elements, such as iodine and sulfur. Aluminum hydroxide, used in medicine as an antacid compound, is one example. Other important inorganic medicinals include magnesium sulfate (Epsom salts), magnesium hydroxide (milk of magnesia), silver nitrate, and salts of iron and mercury.

Fermentation Products

Simply stated, fermentation is a process of chemical manufacture based on the thesis that if a yeast can change grape juice into wine, it is reasonable to suppose that a similar plant organism may provide a short cut in the manufacture of other valuable organic chemicals by transforming one substance into another. The most common example is the way in which pharmaceutical chemists have worked out methods to force Penicillium molds to live and produce the chemical penicillin by deep fermentation methods in huge tanks. In addition, most broad-spectrum antibiotics are produced by the fermentation process,

as well as some hormones, vitamins and other products.

Botanicals

From as far back as recorded history can show, men have been using plants, roots and herbs for medicine. In fact, the *Ebers Papyrus*, an Egyptian medical manuscript dating from about 1600 B. C.—shortly before the time of Moses—mentions a number of drugs which are still familiar today, including castor oil.

As early as 1785, the English physician, Withington, published a treatise on digitalis, the heart stimulant found in the foxglove plant and still widely used. The German chemist, Sertürner, isolated morphine from opium in 1805. Quinine, for treating malaria, was isolated from the bark of the cinchona tree in 1820 by Pelletier and Caventou.

Probably one of the most important botanicals used today is *Rauwolfia serpentina*, the snake-root plant from India, which is useful in the treatment of mental illness and of high blood pressure.

Many substances originally found in plants are now made synthetically or have been replaced by new synthetic compounds. There are many drugs, however, which are still obtained exclusively from plants. Two examples are *Veratrum viride* (green hellebore), used in treating high blood pressure, and *Cascara sagrada*, useful as a laxative.

Crude drugs are prepared from plants by several methods. The portion of the plant containing the active principle may be dried and pulverized, or the active constituent may be extracted with suitable solvents and the solvents evaporated, leaving residual masses or powders. One method of extracting medically useful compounds from crude drugs involves percolation with selected solvents, often alcohol. Further processing is necessary in preparing the drugs for use, and, of course, the preparations must be assayed either chemically or biologically in order to determine the concentration of active ingredient.

Drugs from Animal Sources

Some products for human use are obtained directly from animal tissue. Insulin, for example, is an active principle from the pancreas which affects metabolism and is used in the treatment of diabetes mellitus. ACTH (adreno-cortico-tropic hormone) is extracted from the whole pituitary glands of hogs, sheep and cattle. Sources of these drugs are primarily the meat-packing plants.

To understand the process for producing biological products, it is necessary to have some insight into their medical use.

Infectious diseases are caused by harmful path-

ogens such as bacteria, viruses, fungi, and rickettsiae. These microorganisms can also produce poisons (toxins) which are harmful to the body. Together these microorganisms and the poisons they produce are called "antigens."

One of the human body's defenses against disease is its ability to produce "antibodies"—modified blood-serum proteins which fight the microorganisms, and, in some cases, the toxins. But the body won't produce specific antibodies without some cause—such as a case of measles. Following an attack of measles, for example, antibodies remain in the blood ready to fight a subsequent invasion of the measles-producing organism.

Vaccines

A harmless preparation of microorganisms, called a vaccine, is prepared and administered in order to elicit in the body a response similar to that produced during an infection caused by the same or similar organisms. Vaccines contain antigens which are modified (either killed or live) that are capable of stimulating the production of antibodies, thus helping to create immunity, without causing disease. The antibodies remain in the blood for varying lengths of time, and "booster shots" of vaccine may be advisable for those diseases against which a lifelong immunity is not established.

To prepare bacterial vaccines, each type of bacteria must be grown on a specific diet (culture medium)—usually a gelatin-like substance or broth. Viruses and rickettsiae, on the other hand, which are parasites, must be grown on living tissue. Chicken embryos have proven exceptionally well suited to nourish certain rickettsiae, and the virus causing polio, for instance, thrives best on live cells taken from the kidneys of monkeys.

Smallpox vaccine serves as a good example of a biological. Vaccination (from the Latin *vaccinus*, pertaining to cows) is the term originally devised to describe the method of protecting the body against smallpox. It creates a minor infection in a human being through use of infectious material from cattle diseased with cowpox.

Dr. Edward Jenner administered the first vaccination in 1796 when he inoculated an eight-year-old boy with cowpox taken from the hand of a dairy-maid who had become infected.

Just as a vaccine is a harmless preparation of microorganisms, a toxoid is the toxin produced by certain bacteria that has been rendered harmless. It is administered to protect the body against diseases caused by toxin-producing bacteria, such as diphtheria and tetanus.

Toxins can be prepared artificially by breeding the bacteria in a suitable culture medium—usually a broth made from fresh meat. The bacteria re-

lease their toxins into the broth at certain temperatures. By the application of a chemical, usually formalin, the poisonous property is destroyed. Even though the resulting solution is harmless, it has the ability to stimulate the production of antibodies and thus provide immunity against a later bacterial invasion.

Immune serum, used to combat disease, is taken from the blood of an animal (usually a horse) which has been previously inoculated with a specific antigen to stimulate the development of specific antibodies. Serums are used for curing disease by giving the patient many more antibodies against a specific infection than his own body would be capable of producing once the disease had gained a foothold.

Since the development of antibiotics, serum therapy has not been used widely. Tetanus antitoxin is an important exception. It is usually taken from the blood of horses who have been administered doses of an antigen in slowly increasing amounts for three months. A gradual immunity is built up, trial bleedings determine the maximum antibody content of the blood, and then the animal is bled periodically. Between bleedings the horse is given vitamins and iron to restore its blood and keep it healthy.

Serums prepared to counteract a snake or insect bite are known as antivenoms or antivenins. They are obtained by milking the snake or insect of its venom and injecting it into an animal, from which serum is subsequently obtained.

Products from Human Blood

Plasma has been recognized as a sound substitute for whole blood. In emergencies it is preferable to whole blood because it can be administered regardless of the blood type or Rh factor of the patient.

Each bottle into which a donor gives blood contains an anticoagulant to prevent clotting. The bottle is spun in a centrifuge at high speed to separate the cells, and the plasma is withdrawn from the top. Next, the plasma is irradiated by passing it under ultraviolet lights to reduce the likelihood of bacterial and viral contamination. Then the plasma is shell-frozen along the inside walls of the bottle by revolving it in a 60° below zero (centigrade) alcohol bath. Finally, the containers of frozen plasma are placed in a vacuum drying cabinet in which the ice is removed from the plasma by vaporizing and condensing at low pressure without melting.

Before use, the doctor, hospital pharmacist or nurse restores the plasma to its liquid state by adding distilled water.

Blood carries oxygen, vitamins, minerals, hy-

dolyzed products of carbohydrates, proteins and fats of the digested food absorbed from the gastrointestinal tract, and internally-formed chemicals to the tissues. It also carries the body's weapons against infection. Various components of the blood provide the transportation for these weapons, and many of these components can be isolated for specific therapy by separating the plasma proteins into fractions.

One fraction, gamma globulin, contains a large number of antibodies. It was once known only as a "measles modifier" because of its common injection into children on the assumption that 90 per cent of the adult population had had measles at one time and that their blood contained specific measles antibodies. Before the introduction of the Salk polio vaccine, gamma globulin was widely used for the same reason to help protect the human body against polio. This same fraction can also be used as a specific in the treatment or prevention of whooping cough or mumps, *only* when the globulin itself is derived from blood obtained from professional donors that have been hyperimmunized against these two diseases.

Fibrinogen, one of the newest fractions now commercially available, is used to prevent hemorrhagic episodes that may occur when the level of this fraction is diminished or absent.

The other blood component used extensively in its fractionated form is albumin. It has become a powerful agent for emergency conditions because it is capable of restoring and maintaining, almost immediately, an effective blood volume in case of shock.

Control of Biological Products

These products are deemed so important by the federal government that their production has been under special regulation since 1902. Under the Public Health Service Act of 1944, which superseded earlier legislation, all drug firms producing biologicals for interstate sale must be licensed by the Secretary of Health, Education and Welfare upon the recommendation of the Surgeon General of the U. S. Public Health Service. These regulations provide for repeated inspections of the product in the laboratories, for proper labeling, and for all other safeguards. Equally rigid controls have been established on veterinary products by the Agricultural Research Service.

Manufacturers use a "batch lot" technique in preparing biological material. Protocols describing tests of the manufacturer on each lot must be sent to the Division of Biologic Standards of the National Institutes of Health for testing before the lot is released for sale. Occasionally, samples, too, are required.



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The SS "Disability" Report . . .

Two Provisions of the Social Security Program Require the Worker To Produce a Physical Examination Report from the Physician or Hospital

MORE and more Ohio physicians are finding themselves called upon to provide patients with reports under two comparatively recent provisions of the Social Security program—the disability program for permanently disabled workers 50 to 65 and certain disabled dependents; and the disability "freeze" program. The worker who makes a claim under these provisions will be given certain forms to be filled out, one of which will probably be brought to his physician.

Provisions of the Law

Under the social security disability provisions, monthly benefits may be paid to disabled workers aged 50 to 65, and to their wives and children. Benefits may also be paid, regardless of age, to the dependent disabled sons and daughters of workers who have retired or died.

Disabled workers under age 50 may have their social security records "frozen" to protect their own and their families' rights to future benefits.

Disabled people apply for these benefits or to have their social security records frozen at their nearest social security district offices. The social security district office gives the disabled applicant information about his rights, helps him to fill out his application, and advises him as to the proofs and documents he may need to support that application.

One of the things he will need to get is medical evidence showing the extent of his disability and he is required to obtain this medical evidence at his own expense.

The Medical Report

His social security district office gives him a medical report form on which this medical evidence can be given. He is asked to take or mail this form to his doctor, or to a hospital, institution, public or private agency where he has been treated for his disabling condition.

The form lists the kind of medical facts needed to reach a decision as to whether the patient's impairment is severe enough to meet the definition of "disability" in the social security law.

The use of the form is not mandatory; a narrative summary on the doctor's stationery may be given, if preferred. The report may also be made

on a form used by a hospital, institution, or agency, instead of on the social security form provided. Photocopies of pertinent records are also acceptable. The physician, hospital, or institution returns the completed medical report by mail to the social security office.

Information Needed

The medical report should give the history, symptomatology, clinical findings, and diagnosis in sufficient detail to permit another physician, who will not examine the patient personally, to arrive at a realistic evaluation of the patient's remaining capacity for work.

If available, the report should also give information on the patient's condition at the time he says he first became unable to work.

Sometimes this may require more detailed medical data than the doctor has needed for his diagnosis or treatment of the patient's condition. In the management of a heart patient, for example, such general terms as mild, moderate, or severe are of real significance.

But more precise data are needed to measure the extent of cardiac pathology in determining disability for work. This data should include cardiac size as shown by X-ray or clinical examination, EKG findings, cardiac edema, the amount of dyspnea or angina (described in terms of the number of steps that can be mounted or distance in feet or blocks that the patient can walk), extent of renal involvement, response to therapy, etc.

It should be noted that the attending physician is asked only to provide objective medical data such as this. He is not put in the position of having to determine whether or not his patient is "disabled" under the terms of the social security law.

The Determination

The decision as to whether a person is "disabled" in terms of the severity of his impairment, his work capacity, and employment potential, is made by a "review team" in an agency of the State in which he resides (usually the State vocational rehabilitation agency as is the case in Ohio) under an agreement with the Federal Government. There are at least two professional people on each "team." One is always a doctor of medicine; the other is trained in evaluating the personal and

vocational aspects of disability, such as age, education, and work experience.

The determinations of disability made by the "review team" in the State agency are reviewed by professional personnel in the Bureau of Old-age and Survivors Insurance—personnel trained in evaluating the medical and legal aspects of disability.

Report Is Important

A well prepared medical report can speed the payment of disability benefits to a disabled patient. It will also avoid write-backs for additional clinical or laboratory data. So by preparing comprehensive and specific clinical data for these reports, doctors, nurses, medical librarians, and medical assistants can perform a great service for patients, and also save their own time.

Dr. Helena T. Ratterman, Cincinnati, was one of eight women physicians named "medical women of the year" at the mid-year meeting of the American Medical Women's Association in Washington.

Contracts were awarded recently by the University of Cincinnati on a new wing and remodeling of the U. C. College of Medicine's Holmes Hospital which will increase its bed capacity from 52 to 90.

Complete Exam Fee in VA
Schedule Increased

Effective July 1, 1959, the Veterans Administration Medical Fee Schedule applicable in Ohio will carry the following item:

"Item No. 0141—Complete history and physical examination to determine diagnosis, home or office \$25.00

"Upon prior authorization by the Chief Medical Officer of a Veterans Administration field station or his professional designee, the above service is applicable in the care of eligible veterans with constitutional diseases of a serious or complicated nature which require special study and additional time on the part of the attending physician."

Laboratory procedures required will be paid for in accordance with the established schedule and would not be included in the examination fee.

This was recommended by the Ohio State Medical Association as it was felt this fee would be more nearly adequate in cases where the specialist is asked to do a workup on an unusually serious or complicated case.

Poison Information Centers in Ohio

These centers have agreed to cooperate in a program to extend their services to any physician requesting information from them. When a center is called the physician should have four basic facts in mind: (1) The full name or brand of the product ingested or inhaled; (2) An accurate estimation of the amount of the particular agent ingested; (3) The time of ingestion; (4) The age and weight of the patient.

Location	Facility	Telephone
Akron	Children's Hospital W. Bowery and W. Bechtel	BL 3-5531, Ext. 246
Cincinnati	The Academy of Medicine of Cincinnati 152 E. Fourth St.	PA 1-2345
Columbus	Children's Hospital 561 S. 17th St.	CL 8-9783
Cleveland	Cleveland Academy of Medicine 2121 Adelbert Road	CE 1-4455
Springfield	City Hospital E. High St. and Burnett Rd.	FA 3-5531, Ext. 226
Toledo	Toledo Health Department 635 N. Erie St.	CH 4-1961—(Day) GR 9-2244—(Night)

In Memoriam . . .

Seymour C. Boor, M. D., Creston; University of Wooster, Medical Department, Cleveland, 1898; aged 90; died February 15; member of the Ohio State Medical Association and recipient of the OSMA 50-Year Award. Dr. Boor practiced a total of 60 years. He began his practice in Creston, in 1901 moved to Burbank and in 1923 returned to Creston. Affiliations included memberships in the Lions Club, the Grange and the Methodist Church. His widow and a daughter survive.

Wayne E. Brown, M. D., Clyde; Western Reserve University School of Medicine, 1932; aged 53; died February 20; member of the Ohio State Medical Association and the American Medical Association. Dr. Brown served all of his professional career in Clyde with time out during World War II for a period with the Army Medical Corps. Affiliations included membership in the Masonic Lodge. Surviving are his widow and two sons.

William I. Christian, M. D., Springfield; Medical College of Ohio, Cincinnati, 1891; aged 93; died February 16. Dr. Christian had been a practicing physician in Verona and the Preble County area for more than 50 years before his retirement in 1954. He was a member of the Knights of Pythias. A son survives.

James L. Faragher, M. D., Cleveland; Western Reserve University School of Medicine, 1913; aged 70; died February 6; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. A native of Cleveland, Dr. Faragher served all of his professional career there. He was a member of the Catholic Church, the Catholic Physicians' Guild and the Cleveland Club. Survivors include his widow, four daughters, three sons, two sisters and two brothers.

Kevin J. Fenton, M. D., formerly of Akron; Western Reserve University School of Medicine, 1956; aged 29; died February 25 in a traffic accident in San Francisco where he was stationed with the Navy Medical Corps. Dr. Fenton recently completed a two-year internship in Boston before entering the Navy. He is survived by his parents and two brothers.

Clifford F. Gilmore, M. D., Falls Church, Va.; University of Illinois College of Medicine, 1900; aged 87; died March 2; member of the Ohio State Medical Association and the American Medical Association. Dr. Gilmore practiced medicine for many years in Geauga County before his retirement last year. Surviving are his widow and two daughters.

Forrest L. Keiser, M. D., Columbus; Ohio Medical University, Columbus, 1907; aged 79; died March 7; member of the Ohio State Medical Association and the American Medical Association. Dr. Keiser was a former practicing physician in Columbus and superintendent of the Columbus State School. He was active in a number of organizations, among them the American Association on Mental Deficiency, the Kiwanis Club and several Masonic bodies. His widow survives.

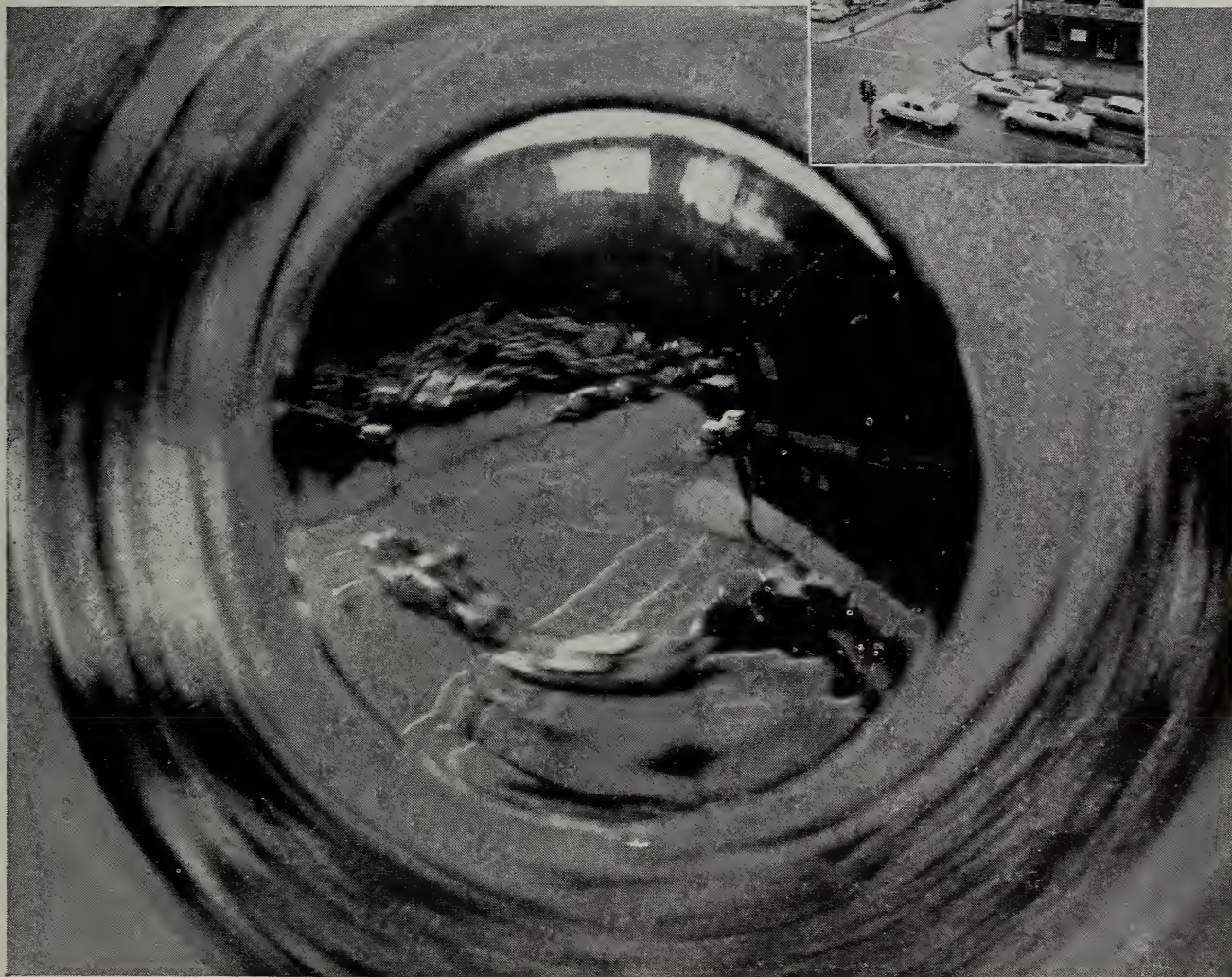
John G. McNamara, M. D., Marion; Ohio State University College of Medicine, 1910; aged 73; died February 13; member of the Ohio State Medical Association and the American Medical Association. Dr. McNamara practiced for about 10 years in Green Camp before he moved his practice to Marion 39 years ago. A veteran of World War I, he was active in numerous organizations. He was past-president of the Pan-American Medical Society; past-president of the Marion County Academy of Medicine; past-president of the Marion Matinee Club and past-president of the Marion County Agricultural Society and a member of the county fair board; member of the Kiwanis Club and several Masonic bodies. Surviving are his widow, a daughter and a sister.

William T. Nelson, M. D., Cincinnati; Howard University College of Medicine, 1904; aged 85; died February 15. Dr. Nelson practiced for 40 years in Cincinnati where he was active in several organizations. He was for many years on the YMCA Board and was active in the AME Church and the Urban League. Two sisters survive.

Nelson M. Rhodes, M. D., Urbana; Cleveland-Pulte Medical College, 1906; aged 78; died February 16; recent member of the Ohio State Medical Association and the American Medical Association; past-president of the Champaign County Medical Society. A native of Urbana, Dr. Rhodes practiced there for 52 years. He was a past-master of the Blue Lodge and belonged to several other Masonic bodies. Survivors include two sons and a sister.

Benton V. Scott, M. D., Waverly; Northwestern University Medical School, 1918; aged 64; died February 16; member of the Ohio State Medical Association, and the American Medical Association; diplomate of the American Board of Preventive Medicine. Dr. Scott since 1955 was health commissioner of the combined district including Chillicothe, Ross, Pike and Highland counties. He formerly did public health work in North Carolina

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*Pratt, R. T. C., and McKenzie, W.: Anxiety States Following Vestibular Disorders, *Lancet* 2:347 (Aug. 16) 1958.

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SEARLE

and in Michigan. Surviving are his widow and four daughters.

Eben B. Shewman, M. D., Cincinnati; Eclectic Medical College, Cincinnati, 1898; aged 82; died February 26; member of the Ohio State Medical Association and the American Medical Association. Dr. Shewman practiced for more than 50 years in the Cincinnati area. He also was active in a number of local organizations, among them the Chamber of Commerce, the Cincinnati Club, the Elks Lodge, several Masonic bodies and the Methodist Church. Surviving are his widow, four daughters and a son.

Edward D. Sinks, M. D., Lima; Medical College of Ohio, Cincinnati, 1899; aged 82; died February 1. A practicing physician in Lima for some 40 years, Dr. Sinks was a veteran of the Spanish American War and World War I. He was a member of the American Legion, Veterans of Foreign Wars and the Masonic Lodge. Surviving are his widow, a son and a daughter.

Roscoe H. Snyder, M. D., Toledo; University of Michigan Medical School, 1927; aged 58; died February 21; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Snyder practiced medicine for 32 years in Toledo. He was active in the Civil Defense program and was medical field service director of the Toledo CD organization. Other interests included the Toledo Yacht Club and the Masonic Lodge. Surviving are his widow, a daughter, a son and a brother.

Harry G. Southard, M. D., Marysville; Starling Medical College, Columbus, 1906; aged 81; died February 16; member of the Ohio State Medical Association and recipient of the OSMA 50-Year Award; member of the American Medical Association.

Dr. Southard began practice in Marysville area with his father, the late Dr. John Q. Southard. In addition to his private practice, he served for many years as Union County health commissioner. He also was state director of health for the term 1931-1934. During the influenza epidemic of 1918 he was assigned by the U. S. Public Health Service to a post in New England. From 1940 to 1953 he was health director for the district including Athens, Vinton and Hocking counties. He was past-president of the Union County Historical Society, served two terms on the Marysville Council and was president of the Marysville Board of Education. He was a past-master of the Masonic Lodge, belonged to several other Masonic bodies and was a member of the Presbyterian Church. Surviving are his widow and two daughters, one of whom is Dr. Martha Southard Carpenter of Merchantville, N. J., and New York City.

Chauncey C. Stewart, M. D., Youngstown; University of Wooster, Medical Department, Cleveland, 1907; aged 81; died February 15; member of the Ohio State Medical Association and recipient of the OSMA 50-Year Award; member of the American Medical Association. Dr. Stewart served all of his professional career in the Poland and the Youngstown area, retiring in 1955. His widow by a second marriage survives.

James Gamble Warner M. D., Pittsburgh, Pa.; University of Wooster Medical Department, Cleveland, 1907; aged 75; died February 24; member of the Ohio State Medical Association and recipient of the OSMA 50-Year Award; member of the American Medical Association. Dr. Warner served all of his professional career in Cleveland with time out during World War I during which he was in the Medical Corps. He was a 50-Year Mason, a member of the Rotary Club and the Cleveland Medical Library Association. Surviving are his widow and three sisters.

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References:

1. Alexander, L.: J.A.M.A. 166:1019, March 1, 1958.
2. Current personal communications; In the files of Wallace Laboratories.
3. Pennington, V.M.: Am. J. Psychiat. 115:250, Sept. 1958.



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Activities of County Societies . . .

First District

(COUNCILOR: CHARLES W. HOYT, M. D.,
CINCINNATI)

CLERMONT

The February 25 meeting of the Clermont County Medical Society was held at the DX Ranch with Dr. O. C. Davison as host. Speaker was Dr. Roy Kile, Cincinnati, whose subject was "Newer Therapeutic Agents in Dermatology."

HAMILTON

A new custom was inaugurated by the Academy of Medicine of Cincinnati at its February meeting when past-presidents' pins were presented to 12 former presidents of the Academy in ceremonies at the Netherland Hilton Hotel. Dr. J. Robert Hudson, president, announced that in the future past-presidents would receive pins on completion of their terms of office.

Those who received the pins were: Drs. E. O. Swartz, oldest living past-president of the organization; George X. Schwemlein, immediate past-president; L. Howard Schriver, John H. Skavlem, Hiram B. Weiss, Charles E. Hauser, J. Stewart Mathews, Daniel E. Earley, Dale P. Osborn, Robert C. Rothenberg, Charles A. Sebastian, Howard D. Fabing, Parke G. Smith, Ralph G. Carothers, Frank H. Mayfield and Cecil Striker.

"The Science of Financial Independence" was the subject of the March 3 meeting of the Academy. Principal speaker was Robert C. Lauer, agent for the Mutual Benefit Life Insurance Company. Participating in the panel discussion in addition to Mr. Lauer were George A. Edwards, account executive of Merrill Lynch, Pierce, Fenner & Smith, Inc.; Richard H. Keys, of Reserve Planning Associates; and Albert G. Schmerge, Mutual Benefit Life Insurance Company.

Second District

(COUNCILOR: R. DEAN DOOLEY, M. D., DAYTON)

CLARK

Springfield and Clark County doctors favor adding fluorine to the city's water.

A motion endorsing such action was passed January 19 by the Clark County Medical Society, meeting in general session in Hotel Shawnee, Springfield.

The society also endorsed a motion for a "low-cost and/or free polio immunization program" for Springfield and Clark County residents. Part of the motion provides for no screening of the medically indigent.

In effect the society gave its blessing to such programs as administered by the Clark County Board of Health and the City Health Department.

Originally, the medical men were to make a decision on a low-cost polio shot program for children of the medically indigent in the county only.

The vote on fluoridating the city's water, supplied by the multi-million-dollar Springfield Water Treatment Plant, north of the city, came after two dentists addressed the doctors.

Dr. John Spencer and Dr. Christie H. Carter, both members of the Mad River Dental Society, urged medical society action on the sometimes controversial subject.

At the February 16 general meeting the medical society heard Dr. William L. Proudfit, of the Cleveland Clinic, talk about coronary disease. Dr. Proudfit has been a member of the clinic staff since 1946. He is a graduate of Washington and Jefferson College and Harvard Medical School.—Tom Duross, Ex-Secretary.

DARKE

"Acute Arterial Occlusions" was the topic discussed by Dr. George Johnson, of Richmond, Ind., at the February 17 meeting of the Darke County Medical Society meeting in Greenville.

MONTGOMERY

"The Generalist and the Specialist" was the topic of Dr. John S. DeTar, of Milan, Mich., at the February 6 meeting of the Montgomery County Medical Society in Dayton. The dinner meeting was at the Van Cleveland Hotel.

Dr. DeTar is a past-president of the American Academy of General Practice and was named Michigan's foremost family doctor in 1948.

The "Medical Citizen of the Year" award was presented by the Society to Dr. R. Dean Dooley, past-president of the Society and Second District Councilor, who has practiced 35 years in Dayton. He has given up his practice and is moving to Columbus to take over his new duties as director of the professional relations program of Ohio Medical Indemnity.

Third District

(COUNCILOR: FLOYD M. ELLIOTT, M. D., ADA)

MARION

Guest speaker for a meeting of the Marion Academy of Medicine on February 2 was Dr. R. Dean Dooley, newly appointed director of Ohio

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Medical Indemnity's professional relations program. He discussed the OMI program.

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

LUCAS

The March calendar of the Academy of Medicine of Toledo and Lucas County included the following program features:

March 6—General Section—"World Crises," Blair Bolles, *Toledo Blade* foreign affairs analyst.

March 12—General Practice Section—"Seminar on Rheumatic Diseases," Dr. Richard T. Messick, clinical instructor in medicine, Ohio State University. This program was sponsored by the Academy of General Practice of Toledo and Lucas County.

March 20 — Medical Section — "Uses and Abuses of the Artificial Kidney," Dr. C. E. Rupe, Henry Ford Hospital, Detroit.

Not previously reported in this column was presentation at the January meeting of the Academy of Medicine of Toledo of three 50-Year Awards. Those honored for more than a half-century of service in the medical profession were Dr. Claude E. Price, Dr. Floyd E. Coultrap and Dr. Victor B. Halbert. All three have served the major part of their practices in the Toledo area.

Fifth District

(COUNCILOR: GEORGE W. PETZNICK, M. D., CLEVELAND)

CUYAHOGA

A special meeting of the Academy of Medicine of Cleveland was held on February 13 under sponsorship of the Academy's Sub-Committee on Traffic Safety. The theme was "Rx for Traffic Safety."

On the afternoon program the following persons participated speaking on the subjects indicated:

Paul H. Blaisdell, director of the Traffic Safety Division of the Casualty and Surety Companies of New York, "Scope of National Problem, Cost and Manpower Losses."

E. R. Dye, engineer, and formerly with the Cornell Aeronautical Laboratories, "Impact and Deceleration Studies—Seat Belts."

Roy Haeusler, safety engineer for Chrysler Motor Corporation, "What More Could the Automobile Industry Do To Provide Safer Vehicles?"

Dr. Robert H. Ebert, professor of Medicine, Western Reserve University, "Medical Licensure of Automobile Drivers."

Following dinner the program was continued with a panel discussion, with Dr. John R. Reed, chairman of the Sub-Committee on Traffic Safety,

as moderator. The panel consisted for the foregoing speakers and the following additional persons: Dr. Samuel R. Gerber, Cuyahoga County coroner; Judge Thomas J. Parrino, Cleveland Municipal Court; J. Grant Keys, director of the Department of Highway Safety for Ohio; Lt. E. E. Smith, public relations officer of the Ohio Highway Patrol, and Paul J. Hoover, president of the Cleveland Safety Council.

A successful meeting and program resulted when the Academy sponsored a public relations clinic and dinner for office workers, nurses and technical aides on February 11. Among those who participated in the program were Miss Beatrice Vincent, career editor of the *Cleveland Press*; Dr. Vincent T. LaMaida, of the Academy's Mediation Committee; Harry Bonfils, of Medical Mutual Insurance Company; Dr. George W. Petznick, Fifth District Councilor.

The evening speaker was Warren Guthrie, TV news commentator whose subject was "People Who Need Talking To."

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

COLUMBIANA

Dr. Frederick Zuspan, assistant professor at Western Reserve University, Department of Obstetrics and Gynecology, discussed recent advances in the practice of office gynecology when he spoke at a dinner meeting of the Columbiana County Medical Society and Auxiliary February 17 at the Wick Hotel in Lisbon.

In his talk to the 65 persons attending, he also recounted the use of hypnosis in selected cases.

The county welfare program was discussed and the society approved the proposed formation of a Northern Columbiana county chapter of the American Red Cross.—*East Palestine Leader*.

STARK

A Symposium on "Recent Developments in Diseases of the Kidney" was presented by the Stark County Medical Society on March 4 in Canton. The program was sponsored by the Northeastern Ohio Chapter of the National Kidney Disease Foundation.

The following Cleveland physicians participated, discussing the subject under the topics indicated:

Dr. Walter Heymann, Department of Pediatrics, Western Reserve, "Classification, Diagnosis and Treatment of Renal Diseases in Children."

Dr. Robert S. Post, Department of Medicine, Western Reserve, "Diagnosis and Treatment of

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Dr. Arthur C. Corcoran, Cleveland Clinic, "Diagnostic and Therapeutic Problems in the Management of Renal Hypertension."

Dr. Lester Persky, Western Reserve, Department of Medicine, "Newer Developments in Urology with Special Reference to Kidney Transplantation."

Dr. William B. Weil, Jr., Western Reserve, Department of Pediatrics, "Fluid and Electrolyte Adjustment in Renal Failure."

Dr. William A. Kelemen, Cleveland Clinic, "Uses and Abuses of Artificial Kidney."

SUMMIT

"The Medicare Program and How It Affects the Private Physician," was the topic discussed at the February 3 meeting of the Summit County Medical Society in Akron. Speakers included John Robert and James Ladgon, Mutual of Omaha representatives.

Dr. Louis M. Hellman, professor and chairman of the Department of Obstetrics and Gynecology, State University of New York Medical School, was speaker at the March 3 meeting of the Summit County Medical Society. His topics of discussion included: "Experiences with the Tubal-Plastic Operation for Sterility"; "Some Interesting Aspects of the New York Contraceptive Problem"; "The Efficacy and Dangers of Oral Contraceptives."

TRUMBULL

Dr. Leonard Lovshin, of the Cleveland Clinic, was guest speaker when the Trumbull County Medical Society met for dinner at the El Rio on February 17. The subject was "Headaches."

Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

BELMONT

The Belmont County Medical Society met February 19 at the Bellaire City Hospital.

Dr. John A. Brown, Morristown, president of the county society, conducted the meeting while Dr. D. M. Creamer, Bellaire, was in charge of the program.

A film, "The Borderline of Cancer—Thyroid, Lungs and Stomach."

Dr. J. F. Wilkinson, chief of staff for the Bellaire hospital, arranged dinner for the group.—*Martins Ferry Times Leader*.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

LAWRENCE

Techniques in medicine in the U. S. and in Russia were discussed—and compared—at a dinner

meeting of the Lawrence County Medical Society February 19 in the Coffee Shop.

Dr. Esther Marting Fabing of Cincinnati was the speaker; she gave observations of her visit to the U. S. S. R., emphasizing the approach to medicine there.

Fifteen members of the county society questioned the former Irononian on diagnosis, techniques and knowledge of medicine by Soviet physicians.

Dr. Fabing was introduced by her father, Dr. W. F. Marting.

In a business session of the quarterly meeting, Dr. Gerard Geswein presided. A discussion of health programs here was instituted by Dr. Raymond Kimbrough, city-county health director.

Dr. Harry Nenni is delegate to the state medical convention with Dr. Geswein, alternate.—*Irononton Tribune*.

SCIOTO

Dr. C. Merle Welch, Department of Anesthesia, Ohio State University, was guest speaker at the February 9 meeting of the Scioto County Medical Society in Portsmouth. He discussed "Respiratory Obstruction as a Problem of the General Physician and Surgeon." A buffet supper followed the program in the Nurses Recreation Hall of General Hospital.

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

FRANKLIN

"Present Uses of Hypnosis in Clinical Medicine" was the subject at the February 18 meeting of the Columbus Academy of Medicine at the Grandview Inn, Columbus. The speaker was Dr. Milton H. Erickson, Phoenix, Arizona, who is president of the American Society of Clinical Hypnosis.

MADISON

The regular monthly meeting of the Madison County Medical Society was held in London, January 14 with W. T. Bacon presiding and the following members in attendance: Bacon, Hurt, Maggied, Marcus, Rosnagle and Wolber. Also present was Dr. Herman Karer, M. D., of Marysville, Ohio.

The minutes of the December meeting and the treasurer's report were read and approved as read.

A resolution opposing Amendment No. 2 to Chapter 4 of the OSMA Bylaws was presented by delegate Maggied and unanimously adopted. A second resolution relative to participation of physicians in formulating rules and regulations which govern high school athletic contests was also unanimously adopted. The secretary was in-

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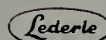
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structed to forward copies of both resolutions to the Executive Secretary of the OSMA.

Under new business, the few minor revisions necessary to bring the Society's recently adopted Constitution and Bylaws into conformity with those of the OSMA were noted, and the Constitution and Bylaws unanimously adopted as revised.

After some discussion it was agreed by common consent that the Society president and/or secretary represent the organization before the Board of Trustees of the Madison County Hospital.

Dr. W. T. Bacon, Madison, county coroner, named Dr. Paul G. H. Wolber, chief deputy coroner and appointed all other medical doctors of Madison County, Dr. Ayulo excepted, to act as assistant coroners. It was pointed out that Dr. Ayulo was not qualified to act in this capacity due to the fact that he had not completed a full year of residence in the county at the time the appointments were announced.

Members selected to serve on Society committees during the current year were named by the chair.

Note was taken of the listing of an osteopath with the M. D.'s in the yellow pages of the current London and Vicinity directory and Dr. Maggied was authorized to protest the listing and request an explanation from responsible officials of the Ohio Bell Telephone Company.

Following the regular business meeting, Dr. Herman Karer, Marysville physician and staff member of the Union County Memorial Hospital, discussed the major problems encountered in the organization and operation of the Union County Hospital. Topics covered included staff membership and bylaws, space considerations, technical services, professional services, nursing service, emergency planning, and records and reports.—Paul G. H. Wolber, M. D., Secretary.

ROSS

Dr. C. V. Yaple was honored at a dinner given by the Ross County Academy at the Colonial Grill. All but two of the academy were present to honor Dr. Yaple, 78, who retired recently after having been in practice for 52 years.

Dr. C. M. Notestone presided and presented gifts from the group to the honored member. Several members offered congratulatory remarks and the doctor responded.—*Chillicothe Gazette*.

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

LORAIN

The February 10 meeting of Lorain County Medical Society was held at the Oberlin Inn.

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Liver diseases presented in a combined symposium and panel session with six sections participating: Internal Medicine, General Practice, Experimental Medicine and Therapeutics, Pathology, Radiology and Gastroenterology.

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David Schachter, New York City, New York

"Hepatic Coma: Its Physiologic and Chemical Basis"

S. P. Bessman, Baltimore, Maryland

"Current Problems in Hepatic Pathology"

I. N. Dubin, Philadelphia, Pennsylvania

"Current Knowledge of Viral Hepatitis"

Joseph Stokes, Jr., Philadelphia, Pennsylvania

"Radiography in the Diagnosis of Hepatic Disease"

John R. Hodgson, Rochester, Minnesota

"Newer Concepts of Cirrhosis"

Gerald Klatskin, New Haven, Connecticut

PANEL DISCUSSION ON HEPATIC DISEASES

Moderator—Cecil Watson, Minneapolis, Minnesota



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Members of the Lorain County Dental Society, represented by 33 persons were guests. In all, 100 persons were present.

Dr. John J. Harrington, anesthesiologist of Lorain, was voted to active membership. Drs. Harry Shecter, pathologist, and Raymundo de la Pena, general physician, both of Elyria, were voted to associate membership.

The evidence of reawakened activity as a county organization calibrated in terms of accepted challenges of problems in Welfare, CIO Golden Age club and local osteopathic developments were all given consideration at this meeting.

Mr. H. C. Bothe of Elyria presented a motion picture on big game hunting in Alaska—heady fare for the busy M. D. who vacations vicariously.

The regular March meeting of the Lorain County Medical Society was held at the Oberlin Inn on March 10. Fifty-one physicians were in attendance. Present also were Dr. H. T. Pease, District Councilor, and Mr. Wayne Stichter, Toledo attorney.

Charles Marten, practicing psychologist, associated with Dr. William J. Feicks, psychiatrist, Lorain, was elected to Honorary Membership.

Regular business was directed to: Pushing Polio Immunization Month, March 15 - April 15; publicly going on record as favoring the fourth polio

shot; establishing plans for a Society sponsored display for the Lorain County fair in August.

Mr. Stichter, as guest speaker, presented a paper on means of avoiding malpractice suits. The scope and clarity of his presentation corroborated OSMA's faith in his ability as its legal counsel.—Lawrence C. Meredith, M. D., Secretary-Treasurer.

General Practitioners Hear Talks On Psychiatric Problems

"Psychiatric Problems Handled by the General Physician," was the theme of the March 1 program of the Southwestern Ohio Society of General Physicians. Local physicians participating in the program were Dr. Maurice Levine, professor and director of the Department of Psychiatry, University of Cincinnati; Dr. Othilda Krug, director, Child Guidance Home, Jewish Hospital; Dr. Samuel J. Neuman, assistant director, Child Guidance Home; Dr. Phillip Piker, professor of clinical psychiatry, University of Cincinnati.

Guest speakers were Dr. William W. Schottstaedt, Department of Medicine, University of Oklahoma; Dr. James A. Grider, medical officer in charge, U. S. Public Health Hospital, Lexington, Ky.; Dr. Heinz E. Lehmann, associate professor of psychiatry, McGill University, Montreal, Canada.



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Medaprin, Upjohn's new analgesic-steroid combination, contains aspirin plus Medrol.** the corticosteroid with *the best therapeutic ratio in the steroid field*.† Instead of suffering recurrent discomfort because of the "wearing off" of analgesics, the patient on Medaprin experiences a smooth, *extended* relief and more normal mobility.

Indications: Medaprin is indicated in mild-to-moderate rheumatic and musculoskeletal condi-

tions, including rheumatoid arthritis, deltoid bursitis, low back pain, neuralgia, synovitis, fibromyositis, osteoarthritis, low back sprain, traumatic wrist, sciatica, and "tennis elbow."

Dosage: The recommended dosage is 1 tablet q.i.d. The usual cautions and contraindications of corticotherapy should be observed.

Supplied: In bottles of 100 and 500.

Formula: Each Medaprin tablet contains

- 300 mg. acetylsalicylic acid, for prompt relief of pain
- 1 mg. Medrol, to suppress the causative inflammation
- 200 mg. calcium carbonate, as buffer

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ANNUAL AUDIT OF BOOKS OF THE OHIO STATE MEDICAL ASSOCIATION AND THE OHIO
STATE MEDICAL JOURNAL FOR YEAR ENDING DECEMBER 31, 1958, BY KELLER,
KIRSCHNER, MARTIN & CLINGER, CERTIFIED PUBLIC ACCOUNTANTS,
COLUMBUS, OHIO

OHIO STATE MEDICAL ASSOCIATION

Cash and Bonds on Hand, January 1, 1958:

Cash in Huntington National Bank:		
Accumulated unexpended income		
of prior years	\$ 22,218.33	
1958 Exhibit payments in 1957	5,462.50	\$ 27,680.83
Cash in Ohio National Bank (1958 Dues)	48,985.00	
U. S. Treasury and Savings Bonds	90,000.00	
Savings Account: Buckeye Federal Savings		
and Loan Association	10,200.43	
Total Cash and Bonds		\$176,866.26

RECEIPTS

Interest on U. S. Treasury and Sav-		
ings Bonds	\$ 2,327.00	
Interest on Savings Accounts	841.37	
1958 Membership dues collected in 1958	170,545.00	
1959 Membership dues collected in 1958	49,700.00	
1958 Exhibit space collected in 1958	10,318.50	
1959 Exhibit space collected in 1958	5,526.25	
Banquet tickets sold	2,115.00	
Payment for collection of American		
Medical Association dues	1,892.74	
Total Receipts		\$243,265.86

Total To Be Accounted For (Includes 1959 Dues and Exhibit Payments Collected in Advance) \$420,132.12

DISBURSEMENTS

The Ohio State Medical Journal	\$ 31,000.00
Executive Secretary, salary	17,500.00
Executive Secretary, expense	1,774.89
Administrative Assistant, salary	9,000.00
Administrative Assistant, expense	1,447.17
Stenographic and clerical salaries	36,752.40
President, expense	1,138.46
President-Elect, expense	320.12
Council expense	3,456.90
American Medical Association Dele-	
gates	5,745.74
Dept. of Public Relations:	
Director, salary	15,000.00
Director, expense	1,126.19
Assistant Director, salary	10,500.00
Assistant Director, expense	1,866.04
Exhibits and newspaper publicity	1,485.46
Literature	509.21
Postage	2,249.57
Supplies	1,014.82
Miscellaneous Activities	3,583.67
Standing Committees:	
Education	25.00
Judicial and Professional Relations	261.39
Public Relations and Economics	477.73
Scientific Work	403.31
Special Committees:	
Auditing and Appropriations; Book-	
keeping	940.00
Chronic Illness	343.33
Government Medical Service	272.28
Hospital Relations	650.02
Industrial Health	292.72
Maternal Health	742.58
Miscellaneous	1,153.45
Rural Health	5,108.48
School Health	1,109.55
Annual Meeting	20,466.10
Conference County Society Presidents	
and Secretaries	1,557.39
Emergency and Equipment Fund	4,105.98
Employees Retirement Fund	5,641.51
Insurance, Bonding, and Social Secu-	
rity Taxes	3,081.10
Legal Expense	10,840.97
Library	157.46
Postage	2,000.00
Professional Relations Activities	9,232.87
Rent and Utilities	9,439.19
Rural Medical Scholarships	2,000.00
Stationery and Supplies	3,714.94
Telephone and Telegraph	3,285.04

Woman's Auxiliary Contribution	1,500.00
Refunds: Dues	55.00
Exhibits	46.00

Total Disbursements \$234,374.03

Cash on Deposit: Bonds; Savings Accounts on Hand, December 31, 1958:

Huntington National Bank:		
Accumulated unexpended income		
for 1958	\$ 9,490.04	
1959 Exhibit payments collected in		
1958	5,526.25	
Total		\$ 15,016.29
Ohio National Bank: 1959 Dues	49,700.00	
U. S. Treasury and Savings Bonds	90,000.00	
Savings Accounts:		
Buckeye Federal Savings and		
Loan Association	10,534.60	
Dollar Federal Savings and Loan		
Association	10,238.79	
Scioto Savings and Loan Co.	10,268.41	

Total Cash, Bonds, and Savings Accounts \$185,758.09

Total Accounted For \$420,132.12

THE OHIO STATE MEDICAL JOURNAL

ASSETS

Current Assets

Cash in Ohio National Bank	\$ 518.75
Petty Cash	30.00
Total Cash	548.75
Accounts Receivable: Advertising,	
net	\$ 14,916.70
Postage deposit	160.00
	15,076.70
Total current assets	\$ 15,625.45

Property Assets:

Furniture and equipment, depreciated value	17,736.73
--	-----------

Total Assets \$ 33,362.18

NET WORTH

Net worth, December 31, 1957	\$ 33,508.76
Net loss for year ended December 31,	
1958	146.58
Total net worth, December 31, 1958	\$ 33,362.18

STATEMENT OF PROFIT AND LOSS

Income:

Advertising, gross	\$ 92,799.85
Less: Commission on advertising	\$ 8,068.01
Cash discount on advertising	570.52
	8,638.53
Advertising, net	\$ 84,161.32
Ohio State Medical Association appropriation	31,000.00
Ohio State Medical Association equipment ap-	
propriation	3,526.90
Subscriptions and sales	1,017.86
1957 Advertising repaid	79.40
Total net income	\$119,785.48

Expenses:

Salaries	\$ 16,363.05
Journal printing	94,102.18
Journal postage	1,561.46
Stationery, printing, and supplies	4,546.99
Illustrations and engravings	748.03
Travel expense	112.62
Miscellaneous postage	314.70
Miscellaneous expense; Audit	150.00
Acoustical Ceiling	249.63
Depreciation	1,783.40
Total expenditures	\$119,932.06
Net Loss for the Year	\$ 146.58

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National Association of Private Psychiatric Hospitals

ACCREDITED: by the Joint Commission on Accreditation of Hospitals

...to postpone
the "G" point*...

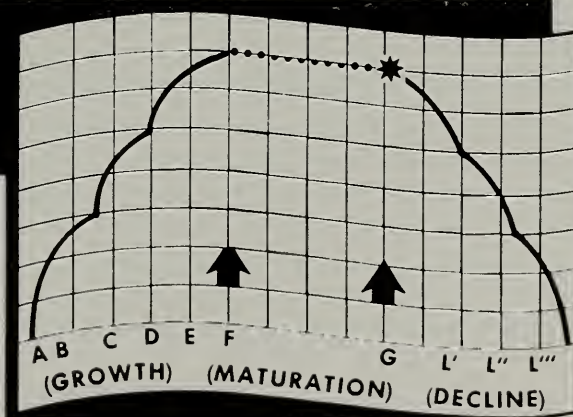
R.....Geritag

For patients over 40, The G POINT (point of declination in life) can be postponed!

Properly balanced Androgen — Estrogen — nutritional therapy may prevent premature aging and damage of gonadal decline and nutritional inadequacy.

Complaints of symptoms such as muscular pain, fatigue, irritability, and poor appetite in the patient over 40 may be the first indications of three major stress factors in the aging process: (1) Gonadal Hormonal Imbalance, (2) Nutritional Inadequacy and (3) Emotional Instability. GERITAG is especially formulated to guard against premature damage and to delay the degenerative process.

Rx GERITAG in preventive geriatrics.



Each Magenta Soft Gelatin Capsule contains:

Methyltestosterone	2 mg.	Thiamine Hcl.	2 mg.
Ethinyl Estradiol	0.01 mg.	Riboflavin	2 mg.
Ferrus Sulfate	50 mg.	Pyridoxine Hcl.	0.3 mg.
Rutin	10 mg.	Niacinamide	20 mg.
Ascorbic Acid	30 mg.	Manganese	1 mg.
B-12	1 mcg.	Magnesium	5 mg.
Malybdenum	0.5 mg.	Iodine	0.15 mg.
Cobalt	0.1 mg.	Potassium	2 mg.
Copper	0.2 mg.	Zinc	1 mg.
Vitamin A	5,000 I.U.	Choline Bitartrate	40 mg.
Vitamin D	400 I.U.	Methionine	20 mg.
Vitamin E	1 I.U.	Inositol	20 mg.
Cal. Pantathenate	3 mg.		

Also available as injectable.

*Chappel, C.C., J.A.M.A., 162: 1414, (Dec. 8) 1956

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Report By Commission On Hospital Accreditation

With the resignation of the Canadian Medical Association, the members of the Corporation of the Joint Commission on Accreditation of Hospitals voted that representation on the Board of Commissioners will be as follows: American College of Physicians, 3 votes; American College of Surgeons, 3 votes; American Hospital Association, 7 votes; American Medical Association, 7 votes.

The commission's report for 1958 shows that as of December 31, there were 3,896 hospitals accredited.

The number of surveys conducted each year has steadily increased. In 1953, the first full year of operation, 1306 surveys were done; in 1958 there were 1688. With the exception of Alaska, all states in the United States were visited and all provinces in Canada.

The proportion of accredited and not accredited results remain fairly constant. In 1958, 89.6 per cent of the surveys done resulted in accreditation and 10.4 per cent resulted in no accreditation.

During 1958, the cost of a survey averaged \$175.14. This figure does not include the sums spent by the American College of Surgeons and the American Hospital Association for overhead expenses of maintaining field staffs. If these were included, the cost per survey would be considerably more.

It is because of this monetary cost and the loss of precious time, that the Commission is very reluctant to cancel or postpone a scheduled survey.

It is ideal to have all key personnel present during a survey, but this is not always possible. The Commission believes that a hospital should not be less effective during the absence of certain individuals. It states if assistants are not able to give the surveyor the information he needs, the administration and control of patient care are not very strong.

A great deal of confusion still exists about the accreditation of hospitals and the approval of intern and resident training programs. The JCAH accredits hospitals only and has no responsibility for the approval of educational programs. The entire responsibility for approving intern and resident training programs is carried by the American Medical Association. Inquiries about these programs should be directed to it.

Physicians interested in future Bahamas Medical Conferences are invited to write: Dr. B. L. Frank, Organizing Physician, Bahamas Conferences, P. O. Box 4037, Fort Lauderdale, Fla.



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After millions of prescriptions, an unexcelled safety record. High, peak blood levels within one hour—plus nearly 100% effectiveness against coccal infections. And, unlike broad-spectrum antibiotics, Erythrocin is classed as a bactericidal antibiotic.

INDICATIONS: Against staph-, strep- and pneumococci. Especially useful when patients are allergic to penicillin or other antibiotics. DOSAGE: For children, 30 mg./Kg. per day. Adults, 1 to 2 Gm. daily, depending on severity of infection. SUPPLIED: in 60-cc., pour-lip bottles. Each 5-cc. teaspoonful represents 200-mg. of Erythrocin activity.

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Activities of Woman's Auxiliary . . .

CHAIRMAN PUBLICITY COMMITTEE—Mrs. W. J. Horger,
1100 Ohio Ave., East Liverpool, Ohio
(See Page 454 for roster of officers.)

ASHLAND

The February meeting of the Ashland County Medical Society was held February 6 at the Ashland Country Club with 17 members and two guests present.

The Councilor of the District, H. T. Pease, M. D., of Wadsworth was a guest and spoke of the coming state meeting, the consideration for the increase in dues of the Ohio State Medical Association, and the scheduled meeting of Medical Society Officers at Columbus February 22.

The speaker of the evening was well received in a talk on "Current Concepts in Psychiatry." This was given by Donald R. Moore, M. D., professor of psychiatry, Indiana University School of Medicine, Indianapolis, who was introduced by M. A. Shilling, M. D., program chairman. His talk traced the early diagnoses of a state mental hospital which he heads at Indianapolis and included such causes given as too much drink, too much work, too much riotous living, being lost in the woods etc., and traced how the diagnoses have changed with the years. He also pointed out that the percentage of the different types of mental illnesses are just about the same regardless of which country is surveyed. The "stress of modern space age living" doesn't seem to make much difference. The speaker also listed and discussed the various present day tools and pointed out that the discharges from mental hospitals now exceed the admissions. His talk was well received.—Wayne C. Smith, M. D., Secretary.

CUYAHOGA

Each year the Woman's Auxiliary to the Academy of Medicine of Cleveland helps to finance a luncheon sponsored by the Cleveland Woman's City Club, and the Council and League for Nursing for the recruitment of nurses. Hon. Francis P. Bolton was guest speaker, and Mrs. F. Rittinger was one of the moderators.

All regular nursing schools, and accredited practical nursing schools were represented by a director and an outstanding student.

The honored guests were 140 high school seniors, who have already signed for a course in nursing. It was interesting to note that every high school in the area was represented.

Auxiliary members under the guidance of Mrs. R. Lowry and Mrs. F. R. Kelly still volunteer

many hours for Civil Defense, better known in Cleveland as the Disaster and Relief Committee. Twenty thousand names, addresses, telephone numbers are constantly kept up to date by doctor's wives.

ERIE

On February 5, members of the Woman's Auxiliary to the Erie County Medical Society were hostesses at a Valentine tea for hospital personnel at Good Samaritan and Providence Hospitals.

The teas at each hospital have grown quite popular and are very well attended. The usual custom has been to have these at Christmas time, but the Valentine theme was decided upon for this year.

At the regular January meeting, a tea was given at the home of Mrs. W. P. Skirball. "New Horizons in Central America" was the topic chosen by Auxiliary member Mrs. George Stimson, when she spoke on her recent trip to Central America.

FAIRFIELD

The February luncheon meeting was held in the home of Mrs. James Beesley, where the AMEF party was held with Mrs. George LeSar, chairman. Auxiliary members weighed in at a cent a pound and provided pennies for progress for AMEF. Each member also paid for her lunch and this money went into the AMEF pot.

A brief explanation of AMEF was used as part of our publicity for the newspaper.

KNOX

On February 25 Miss Ruby Martin, director of nursing service at Ohio State University and the newly elected president of the Central Ohio Nursing League, was guest speaker at the Nurse Recruitment tea at Mercy Hospital, sponsored by the Woman's Auxiliary to the Knox County Medical Society.

Miss Martin spoke on approved schools of nursing in Ohio, various fields of nursing open to young women, and the many scholarships obtainable. A sound movie entitled "When You Choose Nursing," concluded her talk.

All Knox County girls from the 10th, 11th, and 12th grades interested in nursing as a career were invited and some 150 were present and taken on a tour of the hospital by the Gray Ladies of the Red Cross. Refreshments were served in the dining room.

HAMILTON

The January meeting of the Woman's Auxiliary to the Cincinnati Academy of Medicine was called to order by the President, Mrs. Earl Van Horn, following luncheon at the Queen City Club. Dr.

Convenient information for physicians starting diabetic patients on

DIABINESE

simple once-a-day dosage in practice

During the initial control period, the patient should check his urine at frequent intervals, and report at least once weekly for review of symptoms, physical examination, urine and/or blood examination for glucose.

The New Patient (no previous antidiabetic therapy)

1. Initial daily dose 500 mg. (2 tablets of 250 mg. each) with breakfast.
2. In elderly patients, initial dose 250 mg. (1 tablet) daily.
3. CONTROL PERIOD

(a) If blood sugar reaches normal levels after three to seven days, or if glycosuria disappears, lower daily dose of 500 mg. to a level between 250 mg. (1 tablet) and 375 mg. (1½ tablets of 250 mg.) with breakfast daily. In elderly patients, dosage may be reduced to as low as 100 mg.

(b) If hyperglycemia or glycosuria persists or develops, increase the daily dose from 500 mg. to 625 mg. (2½ tablets of 250 mg.) with breakfast daily. In elderly patients, dosage should be increased from 250 mg. according to patient response.

(c) Continue weekly adjustments during first month of therapy until maintenance dose has been established. Adjustments below 250 mg. daily are best made in steps of 100 mg. (one 100 mg. tablet). The maintenance dose may occasionally be as low as 100 mg. (one 100 mg. tablet daily) or, rarely, as high as 1.0 Gm. (four 250 mg. tablets) daily. Do not exceed daily dose of 1.0 Gm.

Transfer of Patient from Insulin

1. If patient is taking 40 or less units of insulin daily and gives no history of severe or "brittle" diabetic response, discontinue insulin and replace with DIABINESE as in The New Patient.
2. Complete control period as for The New Patient. Priming ("loading") doses should not be used.
3. If patient is taking more than 40 units of insulin daily, or shows evidence of severe or brittle diabetes, reduce insulin dose by 50 per cent and initiate DIABINESE therapy as for The New Patient. Further reduction of insulin dosage depends on patient response.

Transfer of Patient from Other Oral Medication

Where less than satisfactory control has been achieved with other oral medication, or where a change to once-a-day dosage is desired, DIABINESE may be successfully substituted. Such a transfer may be made by discontinuing previous oral medication, substituting DIABINESE, and continuing control period as for The New Patient. Avoid priming doses.

The clinical safety of DIABINESE has been established by more than two years' trial. By adherence to the above dosage schedule, side effects of DIABINESE will generally be infrequent, mild, and transient.

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Albert B. Stewart of the Department of Physics and Science, Antioch College, chose as his subject, "Where is Science Taking Us?" The program chairman for the day was Mrs. Elmore Kindel and the hospitality chairman was Mrs. Harvey McCandless.

The annual sale of Xmas cards was most successful. Mrs. Robert Krone, chairman of the committee, reported a total of 23,825 cards sold, yielding \$1300.00. This amount is to be presented to the American Medical Educational Foundation.

Mrs. William Jennings, chairman of the Ways and Means Committee, reported that the annual dinner dance, held in November at the Netherland Hilton Hotel, was attended by 425 members. A check for \$750.00 is to be presented to the Philanthropic Fund, the benefit for which the dance is held.

At the February meeting a style show was presented by the Jenny Company with Mrs. George D. Griffin as commentator. An oriental mood was set for the fashion show by Mrs. Makoto Yamaguchi who modeled an oriental kimono.

LUCAS

A resume of projects which the Toledo Woman's Auxiliary to the Academy of Medicine have accomplished:

August—Lucas County Fair and Health Exhibit, Mrs. Russell Wahl, chairman, Mrs. A. Paul Hancuff, co-chairman.

October 29th—Annual Nurse Recruitment Tea. Mrs. Richard Baer, chairman, presented Student Nurse Mabel Stantz with a three year scholarship in the Maumee Valley Hospital School of nursing, which brought the total of students being sponsored by the Auxiliary to four this year. Oct. 24—Community Chest team under chairmanship of Mrs. Daniel Radecki made 101 per cent of its goal.

November 11th—Fourth District meeting at the home of Mrs. C. J. A. Paule, District Director. 12th—Fund Raising Theatre Premiere of "La-Rouge Et Noir" under chairmanship of Mrs. W. L. Woodward and Mrs. John B. Rank. Very successful.

January 15th—"Mother's March" Tea for the National Foundation Drive members. This drive is sponsored by our Auxiliary and all material is packed by members and distributed to the captains of the teams at the Tea. Mrs. Wm. Phillips, chairman, and Mrs. Rolland Kennedy have been commended for their efforts by the local National Foundation Headquarters.

January 31st—Annual Auxiliary Dance featured the theme of "Mardi Gras."

February—The Toledo area American Associa-

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Dosage: one tablet before each meal.

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References: 1. Charles, C. M.: *Geriatrics* 2:110 (March) 1956. 2. Menger, H. C.: *Clin. Med.* 4:313 (March) 1957. 3. Shuster, B. H.: *M. Clin. North America* 40:1787 (Nov.) 1956.



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tion Physician and Surgeon Essay contest launched is under the chairmanship of Mrs. Gordon Todd.

MAHONING

The February 19 meeting of the Auxiliary to the Mahoning County Medical Society was a guest night at the new Youngstown Playhouse. One hundred fifty members, husbands and guests saw the opening performance of the musical production, "Finian's Rainbow." This was the first time the new Arena Theater had been used, and the first Play-in-the-Round presented in the new Playhouse.

The room was made especially colorful with the new red and white chairs which were in part made available by a donation of \$150.00 from the Auxiliary. Following the play, a buffet lunch was attractively served in the large rehearsal hall.

ROSS

Five inactive charter members of the Woman's Auxiliary to the Ross County Medical Society were among the guests at the auxiliary's luncheon Thursday at the Warner Hotel. Welcomed back by the president, Mrs. Robert Quinn, were Mrs. George Cooper, Mrs. Frank Marr, Mrs. Ward B. Smith, Mrs. Harry Brown and Mrs. George Mytinger.

Mrs. Quinn also introduced three members of the Pike County Medical Auxiliary, Mrs. Cooper, Mrs. Robert Andre and Mrs. Mickey Netherton. The President then turned the meeting over to Mrs. Garrett, vice-president and program chairman, who introduced Mrs. Rivington Fisher of Columbus, director of District 10, Ohio Medical Auxiliary.

Guest speaker at the meeting was Mrs. Charles Harding of Columbus, vice-president of the Ohio Medical Auxiliary. She was introduced by Mrs. Quinn and her topic was "A Good Doctor's Wife."

Mr. Edgar Zimmerman, Red Cross chairman, also spoke briefly to the group. He congratulated Chillicothe on its total community response in the recent disaster and commended the medical and nursing professions for their wonderful work. He was introduced by Mrs. Howard Wood, public relations chairman.

Mrs. James Manchester reported on the Stork Club, a course for expectant mothers, scheduled on two days in February at Chillicothe hospital.

SCIOTO

One of the highlights in the local Nursing Week was a recruitment tea given at Madonna Hall, the nurses home of Mercy Hospital, by the Woman's Auxiliary of Scioto County Medical Society to interest high school girls in a nursing career.

Approximately 425 girls from the city and county high schools were conducted on a tour of

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Mercy Hospital and its School of Nursing preceding the afternoon tea.

Mrs. Clyde M. Fitch served as chairman of the tours.

Mrs. Joseph T. Gohman was chairman of the tea and the decorations were in charge of Mrs. Wm. M. Singleton.

Serving at the tea table were Mrs. Samuel L. Meltzer and Mrs. Armin A. Melior.

Following the tea Mrs. Melior presided over a business meeting of the auxiliary.

TRUMBULL

The Auxiliary to the Trumbull County Medical Society met for lunch on Thursday, February 19, at St. Joseph's hospital. Honorary members and past presidents were guests. Each guest received a pink carnation corsage.

The business meeting was conducted by the President, Mrs. John Grima. She asked for written reports from all the committee chairmen for the State Credits and Awards contest. The *Today's Health* chairman reported a 100 per cent subscription sale for this year. The Volunteer Service chairman reported on help given by the auxiliary members during the recent flood in this area.

The Mental Health Committee reported that a film was being used for a PTA program and the Nurse's Recruitment Committee reported that it had one which was being shown at three Future Nurse's Clubs in the county. It was announced that the series of radio programs on child study, sponsored by the Auxiliary and broadcast over the local station would continue this month with another panel discussion.

The program arranged for this meeting was a talk by Mrs. Olga Cornell on her hobby "Bottles Can Be Fun." She gave a brief history of early bottles and displayed the collection which she had brought with her.

More Prominent Listing of Trade Names Announced

In order to make descriptions of drugs more easily identified by physicians who may be familiar with only their commercial names, the Council on Drugs of the American Medical Association has voted to place these names in parentheses immediately after the nonproprietary titles of all subsequently published monographs (and in supplemental statements on previously evaluated drugs), instead of at the end or in the text of such descriptions. This change in format is being implemented simultaneously in *The Journal of the AMA* and for the 1960 edition of *New and Non-official Drugs*.



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STARTING DATES — SPRING, 1959

SURGERY—Surgical Technic, two weeks, Apr. 27, June 1. Surgery of the Colon & Rectum, one week, June 1. Gallbladder Surgery, three days, June 1. Surgery of Hernia, three days, June 4. General Surgery, one week, May 25. Board of Surgery Review Course, Part II, two weeks, May 11. Blood Vessel Surgery, one week, June 22. Breast & Thyroid Surgery, one week, May 4. Femoral Arteriography, 4 days, May 12. Pediatric Surgery, one week, June 1. Fractures & Traumatic Surgery, two weeks, June 15.

GYNECOLOGY & OBSTETRICS—

Office & Operative Gynecology, two weeks, June 15. Vaginal Approach to Pelvic Surgery, one week, June 8. General & Surgical Obstetrics, two weeks, May 4.

MEDICINE—Two-Week Intensive Course, May 11. Hematology, one week, May 25. Board of Internal Medicine Review Course (Part II), one week, May 25. (A one week course for Part I applicants will begin on September 14)


RADIOLOGY—Diagnostic X-Ray, two weeks, April 27 and June 15. Clinical Uses of Radioisotopes, two weeks, May 4.

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New Members of OSMA

The following are the names of the new members of the Ohio State Medical Association since February 1, 1959. The list shows the county in which they are affiliated, city in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

Allen County

Wesley E. Shankland, Lima

Butler County

Paul V. Kuenzig, Hamilton
Harold C. Rothermel,
Middletown

Champaign County

Fred Denkwalter, Urbana

Clark County

Leo A. Lucas, Springfield

Cuyahoga County

Cahit Corbacioglu, Cleveland
John A. Hadden, Jr.,
Cleveland
William G. Lockhart,
Cleveland
Ira M. Levy, Cleveland
Elga M. Mazkalinis,
Cleveland
Samuel M. Mendlovic,
Cleveland
Jack F. Ross, Cleveland
Alvin S. Segel, Cleveland
Wildtraut Szolomayer,
Cleveland

Franklin County

Waldemar Bergen, Columbus
Ronald A. Mezger,
Worthington
Walter A. Thomas,
Columbus

Gallia County

Thomas M. Hamilton,
Gallipolis

Hamilton County

Dover A. Dick, Cincinnati
George G. Hibbs, Cincinnati
Marcus M. Key, Cincinnati
Franz J. Nave, Cincinnati

Highland County

David S. Ayers, Hillsboro

Lake County

Lloyd E. Johnson,
Willoughby

Logan County

James T. Enochis,
West Liberty

Lorain County

Raymundo de la Pena,
Elyria
Harry Shecter, Elyria

Lucas County

Albert Endrody, Toledo
Jay M. Hallauer, Toledo
Ward S. Jenkins, Toledo
Margaret B. Miller, Toledo
Hilbert Mark, Toledo

Mahoning County

Henry S. Ellison,
Youngstown
Curtis J. Fisher, Youngstown
David R. Ginder,
Youngstown
Allen H. Holt, Youngstown
John A. Hyland,
Youngstown
Julius Nemeth, Youngstown
Samuel F. Petraglia,
Poland
Arthur V. Whittaker, Poland

Marion County

Louis J. Cherry, Marion
John M. Kearney, Marion
Ping C. Ling, Marion

Mercer County

Joseph F. Vormohr,
Ft. Recovery

Miami County

Constantine Pereyma, Troy

Montgomery County

Dale O. Porter, Dayton
John W. Washington,
Dayton

Richland County

Alexander M. Dull, Jr.,
Mansfield

Stark County

Mircea Lengyel, Canton
G. Nevin Shuey,
Canal Fulton

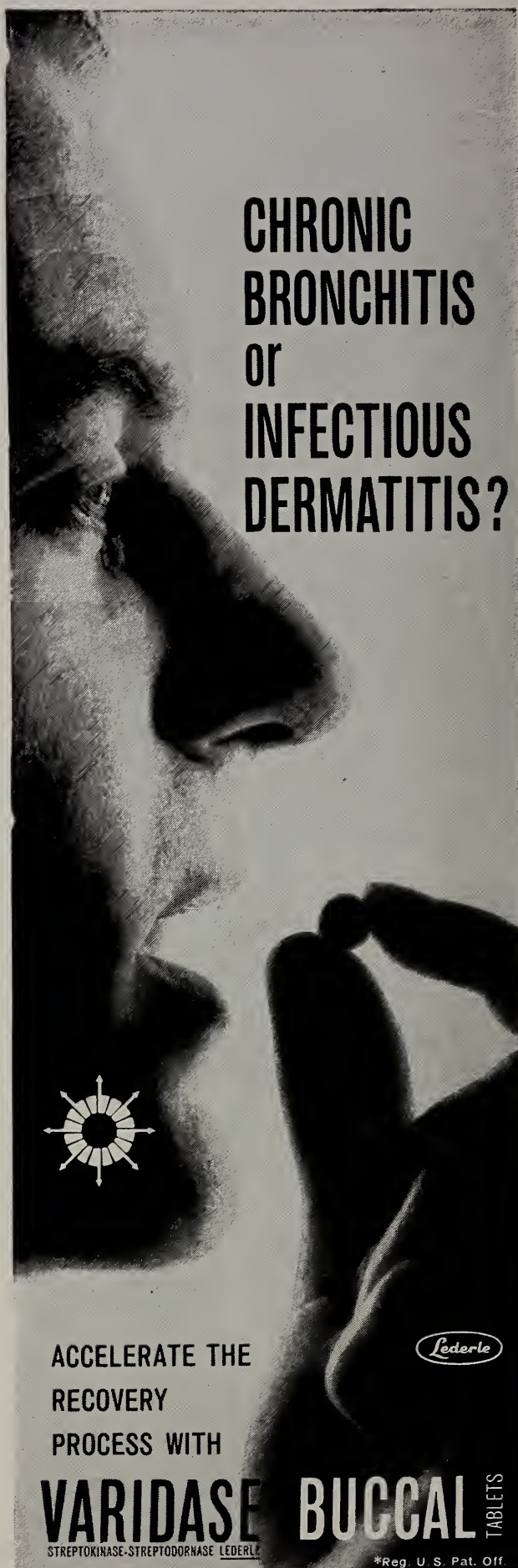
Summit County

Laurence H. Ballou, Akron
George T. Conger, Akron
Charles E. Couch, Mogadore
William Dorner, Jr., Akron
John F. McVay, Akron
Ronald B. Mitchell, Akron
Douglas W. Sanders, Akron
Thomas Scarlett, Akron
John A. Soquel,
Cuyahoga Falls

Trumbull County

Guy R. Musser, Warren

In 1958, for the second year in a row, the general death rate for the United States is higher than it was in 1956. The increase, however, was quite moderate. The death rate for 1958 is estimated to be 9.6 per 1,000 population—the same as it was for 1957—which is only 2 per cent above that for 1956 and 4 per cent above the all-time low of 9.2 established in 1954. For 11 years in succession now the mortality rate in our country has been below 10 per 1,000.—*Metropolitan Life.*



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STAPHYLOCOCCAL INFECTIONS

Excerpts from Reports Read at the Antibiotics Symposium

Spontin In Treating Severe Respiratory Infections

—“In 13 of 20 patients the results were excellent, with clinical response being evident within one to four days after institution of therapy. In three additional patients, there was some degree of improvement in pneumonic processes superimposed on tuberculosis in two cases and on pulmonary neoplasia in one. In all other cases, serious antecedent pathology undoubtedly influenced the negative or equivocal response to ristocetin therapy.⁶”

Spontin In Treating Staphylococcal Infections

—After successfully treating 28 patients, the authors wrote, “Ristocetin or Spontin has proved to be bactericidal and bacteriostatic, particularly for the *Staphylococcus aureus*, which is often resistant to many other antibiotics.⁵”

Spontin In Treating Seven Difficult Cases

—“Ristocetin has produced excellent results in eradicating, mitigating or preventing infection in seven selected difficult cases. Six of the seven cases involved *Staphylococcus aureus* which did not respond to chemotherapy with other antibiotics.⁷”

Spontin Blood Levels In Children

—“Ristocetin was administered as a single intravenous injection of 12.5 milligrams per kilogram. This resulted in serum levels ranging from 1.3 to 10.6 mcg. after two hours with a gradual fall to a level of 0.7 mcg. per cubic centimeter or less after 12 hours.⁸”

Spontin In Treating Staphylococcal Pneumonia

—“Ristocetin was used in the treatment of 24 patients with staphylococcal pneumonia, 17 of whom had failed to respond to previously administered antibiotics. Complete clearing of pneumonitis was obtained in 16 patients and significant improvement occurred in two others. Two patients died of pneumonia; four others succumbed to other lethal diseases.⁹”

Spontin In Treating Children and Adults

—“Ristocetin completely controlled severe staphylococcal infections in 11 adults and six children who received adequate therapy.¹⁰”

1. Totals represent published reports and personal communications to Abbott Laboratories.
2. Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 15, 16, 17, 1958.
3. Romansky, M. J., and Holmes, R., Successful Short-Term Therapy of Enterococcal and Staphylococcal Endocarditis with Ristocetin—Seven Patients. Preliminary Report, Antibiotics Annual, 1957-58, p. 187.
4. J. A. M. A., 167:1584, July 26, 1958.
5. Bush, L. F., et al., The Use of Ristocetin (Spontin) in Staphylococcal Infections, In Press, Antibiotics Annual, 1958-59.
6. Billow, F. J., et al., Clinical Observations on Ristocetin—A Preliminary Report on its Efficacy and Toxicity in 20 Unselected Severe Respiratory Infections, In Press, Antibiotics Annual, 1958-59.
7. Miller, J. M., et al., Ristocetin in the Treatment of Seven Selected Difficult Cases, In Press, Antibiotics Annual, 1958-59.
8. Asay, L. D., et al., Ristocetin Serum Levels in Children, In Press, Antibiotics Annual, 1958-59.
9. Schumacher, L. R., et al., Experiences with Ristocetin in Staphylococcal Pneumonia: Observations in 23 Cases, In Press, Antibiotics Annual, 1958-59.
10. Terry, R. B., Ristocetin in Children and Adults, In Press, Antibiotics Annual, 1958-59.

COMING MEETINGS

Ohio State Medical Association, 1959 Annual Meeting, April 21-24, Columbus.

American Medical Association, Annual Session, Atlantic City, N. J., June 8-12.

Akron Academy of Ophthalmology and Otolaryngology, Postgraduate Course in Allergy and Endocrinological Aspects of Allergy, Ohio Building, Akron, May 4-6.

AMA Law Department, Regional Medicolegal Conference, Hotel Cleveland, Cleveland, April 4-5.

Chest Disease Symposium for General Practitioners, Saranac Lake, N. Y., July 6-10.

Cleveland Society of Anesthesiologists, Meeting, Tudor Arms Hotel, Cleveland, May 20.

Northwestern Ohio Medical Association, Findlay Country Club, October 7, all-day session; registration 9:00 a.m.; first speaker, 9:45 a.m.

Northern Tri-State Medical Association, 86th Annual Meeting, Marshall, Mich., May 7.

Ohio Orthopaedic Society, Meeting, Akron, April 10, 11.

Ohio State Surgical Association, 1959 Annual Meeting, Cleveland, June 3-4.

Ohio State Radiological Society, Annual Meeting, Terrace-Hilton Hotel, Cincinnati, May 8-10.

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Delegates and Alternates to the American Medical Association—Paul A. Davis, Akron; Edmond K. Yantes, Wilmington, alternate; Charles L. Hudson, Cleveland; H. T. Pease, Wadsworth, alternate; Carl A. Lincke, Carrollton; Robert S. Martin, Zanesville, alternate; Carl S. Mundy, Toledo; Paul F. Orr, Perrysburg, alternate; L. Howard Schriver, Cincinnati; Charles A. Sebastian, Cincinnati, alternate; C. C. Sherburne, Columbus; Richard L. Meiling, Columbus, alternate; George A. Woodhouse, Pleasant Hill; R. Dean Dooley, Dayton, alternate; Herbert B. Wright, Cleveland; Fred W. Dixon, Cleveland, alternate.

COUNTY SOCIETIES' OFFICERS AND MEETING DATES

FIRST DISTRICT

ADAMS—Samuel B. Sonkin, President, Main St., West Union; Alexander Salamon, Secretary, Seaman. 3rd Wednesday, April, June, August, October and December.

BROWN—Vytautas Karoblis, President, 410 Main St., Ripley; Charles William Hannah, Secretary, Sardinia. 1st Sunday, monthly.

BUTLER—Clyde G. Chamberlin, President, 300 Rentschler Bldg., Hamilton; Mr. Charles G. Greig, Executive Secretary, 110 N. Third St., Hamilton. 4th Wednesday of alternate months.

CLERMONT—Cecil F. Barber, President, Felicity; Harry M. Breuer, Secretary, 224 George St., New Richmond. 3rd Wednesday, monthly.

CLINTON—Robert M. Cronebaugh, President, 116 N. Broadway, Blanchester; John K. Williams, Secretary, 100 W. Main St., Wilmington. 2nd Tuesday, monthly.

HAMILTON—J. Robert Hudson, President, 152 E. Fourth St., Cincinnati 2; Mr. Edward F. Willenborg, Executive Secretary, 152 E. Fourth St., Cincinnati 2. 3rd Tuesday, monthly. September through May.

HIGHLAND—J. Martin Byers, President, 316 Midway, Greenfield; Kenneth Lyle Upp, Secretary, 136 S. Washington St., Greenfield. 1st Wednesday, monthly.

WARREN—Thomas E. Fox, President, 309 Reading Rd., Mason; D. Paul Ward, Secretary, Box 85, Pleasant Plain. 2nd Tuesday, monthly.

SECOND DISTRICT

CHAMPAIGN—John R. Polsley, President, Box 183, N. Lewisburg; Theodore E. Richards, Secretary, 118 Scioto St., Urbana. 2nd Wednesday, monthly.

CLARK—William P. Montanus, President, 301 Home Rd., Springfield; Martin J. Cook, Secretary, 1054 E. High St., Springfield. 3rd Monday, monthly.

DARKE—Jesse L. Heise, President, Pitsburg; Emmett W. Arnold, Secretary, Court House, Greenville. 3rd Tuesday.

GREENE—Paul C. Vernier, President, 67 Xenia Drive, Fairborn; Quinten L. Erd, Secretary, S. Limestone, Jamestown. 2nd Thursday, monthly.

MIAMI—William W. Weis, President, 404 W. Wayne St., Piqua; John W. Gallagher, Acting Secretary, 407 W. High St., Piqua. 1st Friday, monthly.

MONTGOMERY—Alvin J. Carlson, President, 878 Reibold Bldg., Dayton; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Medical Bldg., Dayton 2. 1st Friday.

PREBLE—E. P. Trittschuh, President, 309 E. Main St., Lewisburg; Birna R. Smith, Secretary, 203 Commerce St., Lewisburg.

SHELBY—Clayton B. Conover, President, 316 S. Main Ave., Sidney; Ned A. Smith, Secretary, 739 Spruce St., Sidney. 1st Tuesday, monthly.

THIRD DISTRICT

ALLEN—Roger L. Tecklenberg, President, 700 Cook Tower, Lima; Thomas D. Allison, Secretary, 401 Steiner Bldg., Lima. 3rd Tuesday, monthly, except June, July, August.

AUGLAIZE—Robert J. Herman, President, 611 W. Mechanic St., Wapakoneta; Robert S. Oyer, Secretary, 310 Perry St., Wapakoneta. Called meetings.

CRAWFORD—Donald R. Wenner, President, 117 S. Poplar St., Bucyrus; Arnold Eicns, Secretary, 406 S. Sandusky St., Bucyrus. 3rd Thursday, monthly.

HANCOCK—M. Wesley Feigert, President, Ohio Bank Bldg., Findlay; Benjamin H. Saunders, Jr., Secretary, 1900 S. Main St., Findlay. 3rd Tuesday, monthly.

HARDIN—Raymond G. Schutte, President, 110 E. Columbus St., Kenton; Jack C. Lindsey, Secretary, 214 N. Main St., Kenton. 2nd Tuesday, monthly.

LOGAN—Charles A. Browning, Jr., President, 445 E. Columbus Ave., Bellefontaine; Paul E. Hooley, Secretary, N. Main St., DeGraff. 1st Friday, monthly.

MARION—Thomas N. Quilter, President, 1040 Delaware Ave., Marion; Robert L. Stuber, Secretary, 399 E. Church St., Marion. 1st Tuesday, monthly.

MERCER—Julius Schwieger, President, Fort Recovery; Terrence J. Kerrigan, Secretary, 204 W. North St., Coldwater. 3rd Thursday, monthly.

COUNTY SOCIETIES' OFFICERS AND MEETING DATES (Continued)

SENECA—Thomas W. Watkins, President, 34 W. Market St., Tiffin; Robert R. Schwalenberg, Secretary, 34 W. Market St., Tiffin. 3rd Tuesday, every other month.

VAN WERT—Jack H. Cox, President, 301 N. Washington St., Van Wert; Ralph E. Razor, Jr., Secretary, 507 S. Washington St., Van Wert.

WYANDOT—Clarence B. Schoofield, President, 206 S. Main St., Upper Sandusky; Franklin M. Smith, Secretary, E. Saffle Ave., Box 68, Sycamore. 2nd Tuesday, monthly, except July and August.

FOURTH DISTRICT

DEFIANCE—Thad J. Earl, President, 1132 E. Second St., Defiance; Francis M. Lenhart, Secretary, 207 Summit St., Defiance.

FULTON—Edwin R. Murbach, President, 224 N. Defiance St., Archbold; Robert A. Ebersole, Secretary, 203 DeGroff Ave., Archbold. 2nd Tuesday, monthly.

HENRY—Edwin C. Winzeler, President, 812½ N. Perry St., Napoleon; Thomas F. Tabler, Secretary, 332 Railway Ave., Holgate. 1st Tuesday, monthly.

LUCAS—Maurice A. Schnitker, President, 1006 Secor Hotel, Toledo 3; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Blvd., Toledo 10. 3rd Tuesday, monthly.

OTTAWA—Cyrus R. Wood, President, 115 Madison St., Port Clinton; Robert W. Minick, Secretary, 124½ W. Water St., Oak Harbor. 2nd Thursday, monthly.

PAULDING—Edythe C. Pritchard, President, 509 N. Williams St., Paulding; D. E. Farling, Secretary, Main St., Payne. 3rd Wednesday, monthly.

PUTNAM—Walter E. Martin, President, 135 N. High St., Columbus Grove; Will W. Moody, Secretary, Vaughnsville. 1st Tuesday, monthly.

SANDUSKY—R. Allen Eyestone, President, Gibsonburg; Paul E. Burson, Secretary, Cor. Southwest & Center St., Bellevue. 3rd Wednesday, monthly.

WILLIAMS—Robert W. Dilworth, President, Main St., Montpelier; E. K. Bell, Secretary, P. O. Box 466, Bryan. Monthly meeting date varies.

WOOD—Stewart J. Smith, President, 106 N. Main St., Bowling Green; Richard L. Pearse, Secretary, 320 S. Main St., Bowling Green. 3rd Thursday, monthly.

FIFTH DISTRICT

ASHTABULA—Lewis H. Roth, President, 80 S. Broadway, Geneva; Albin F. Urankar, Secretary, Ashtabula Gen. Hospital, Ashtabula.

CUYAHOGA—Chester R. Jablonoski, President, 7211 Broadway, Cleveland; Mr. Robert A. Lang, Executive Secretary, 2009 Adelbert Rd., Cleveland. 2nd Tuesday, monthly.

GEAUGA—George Dandalides, President, Chardon Medical Center, Chardon; Alton W. Behm, Secretary, 112 South St., Chardon. 2nd Friday, monthly.

LAKE—Richard W. McBurney, President, 124 S. St. Clair St., Painesville; Mrs. Owen A. McLaren, Executive Secretary, 1051 Cadle Ave., Mentor.

SIXTH DISTRICT

COLUMBIANA—William A. Kolozsi, President, 616 E. Seventh St., Salem; Leonard S. Pritchard, Secretary, 153 S. Main St., Columbiana. 2nd Tuesday, monthly.

MAHONING—M. W. Neidus, President, 318 Fifth Ave., Youngstown; Mr. Howard C. Rempes, Jr., Executive Secretary, 245 Bel-Park Bldg., 1005 Belmont Ave., Youngstown 4. 3rd Tuesday, monthly.

PORTAGE—Charles C. Whitsett, President, Robinson Memorial Hospital, Ravenna; Don P. VanDyke, Secretary, 607 E. Main St., Kent. 3rd Tuesday, monthly.

STARK—John R. Seesholtz, President, 1645 Cleveland Ave., N.W., Canton; Mr. E. M. Sprunger, Executive Secretary, 405 Fourth Street, Canton 2. 2nd Thursday, monthly, except May, June, July, August and September.

SUMMIT—Donald I. Minnig, President, 640 W. Market St., Akron; Mr. S. H. Mountcastle, Executive Secretary, 437 Second National Building, Akron. 1st Tuesday, monthly, September through June.

TRUMBULL—Paul E. Noonan, President, 238 N. Park Ave., Warren; Ralph H. Jamison, Secretary, 197 W. Market St., Warren. 3rd Wednesday, monthly.

SEVENTH DISTRICT

BELMONT—John A. Brown, President, Morristown; Bertha M. Joseph, Secretary, 100 S. Fourth St., Martins Ferry. 3rd Thursday, monthly.

CARROLL—Samuel L. Weir, President, 625 N. Market St., Minerva; Robert C. Lanzer, Secretary, 625 N. Market St., Minerva. 1st Thursday, monthly.

COSHOCTON—Lewis E. Smith, Jr., President, 729 Main St., Coshocton; Harold W. Lear, Secretary, 110 N. Seventh St., Coshocton. 2nd Tuesday, monthly.

HARRISON—Elias Freeman, President, 264 S. Main St., Cadiz; Janis Trupovnieks, Secretary, High St., Box 366, Hopedale.

JEFFERSON—Ernest L. Perri, President, 517 N. Fourth St., Steubenville; Jacob Mervis, Secretary, Sinclair Bldg., Steubenville. 2nd Tuesday, monthly.

MONROE—Byron Gillespie, Secretary, South Main Street, Woodsfield.

TUSCARAWAS—Chester A. Bennett, President, 533 Wooster Ave., Dover; George D. Woodward, Secretary, 201 Boulevard, Dover. 2nd Thursday, monthly.

EIGHTH DISTRICT

ATHENS—T. J. Najm, President, 422 W. Washington St., Nelsonville; Charles R. Hoskins, Secretary, Security Bank Bldg., Athens. 2nd Tuesday, monthly.

FAIRFIELD—Lloyd L. Kersell, President, 130 Union St., Lancaster; Arthur B. VanGundy, Secretary, 843 N. Columbus St., Lancaster. 2nd Tuesday, monthly.

GUERNSEY—Jesse B. Kellum, President, 840 Wheeling Ave., Cambridge; Thomas D. Swan, Secretary, 651 Wheeling Ave., Cambridge. 1st Thursday, monthly.

LICKING—Kurt J. Fleisch, President, 125 Hudson Ave., Newark; Jay Ross Wells, Secretary, 375 Granville St., Newark. Last Tuesday, monthly.

MORGAN—A. H. Whitacre, President, Chesterhill; C. E. Northrup, Secretary, Corner Main and Seventh St., McConnellsville. Called meetings.

MUSKINGUM—J. Herbert Bain, President, 67 W. Main St., New Concord; William A. Knapp, Secretary, 1025 Maple Ave., Zanesville. 1st Tuesday, monthly.

NOBLE—Charles F. Thompson, President, Caldwell; E. G. Ditch, Secretary, Caldwell. 1st Tuesday, monthly.

PERRY—Charles E. Bope, President, Somerset; O. D. Ball, Secretary, 203 N. Main St., New Lexington. Called meetings.

WASHINGTON—William R. Stewart, President, 407 Second St., Marietta; Donald S. Williams, Secretary, 222 Third St., Marietta. 2nd Wednesday, monthly.

NINTH DISTRICT

GALLIA—Thomas W. Morgan, President, Holzer Hospital, Gallipolis; Norman W. Pinschmidt, Secretary, Gallipolis Clinic, 52 State Street, Gallipolis. 3rd Thursday, monthly.

HOCKING—George B. Watson, President, Box 296, Adelphi; Howard M. Books, Secretary, Court House, Logan. Indefinite meeting dates.

JACKSON—Tom Washam, President, 35 Vaughn St., Jackson; Brinton J. Allison, Secretary, 267 Ralph St., Jackson. Called meetings.

LAWRENCE—Gerard C. Geswein, President, 1626 S. Sixth St., Ironton; George Newton Spears, Secretary, 2213 S. Ninth St., Ironton. Monthly meetings on call.

MEIGS—Charles J. Mullen, President, 210½ E. Main St., Pomeroy; Selim J. Blazewicz, Secretary, 112½ E. Main St., Pomeroy. Last Wednesday, monthly.

PIKE—Paul H. Jones, President, Stockdale; George W. Cooper, Secretary, Piketon. 1st Tuesday, monthly.

SCIOTO—Ralph W. Lewis, President, 1025 Ninth St., Portsmouth; Carl H. Laestar, Secretary, 2829 Gallia St., Portsmouth. 2nd Monday, monthly.

VINTON—Richard E. Bullock, President, McArthur; H. D. Chamberlain, Secretary, W. Main St., McArthur.

TENTH DISTRICT

DELAWARE—Max W. Livingston, President, 28 North Vernon, Sunbury; Edward C. Jenkins, Secretary, c/o Mrs. Mabel Barrett, Jane M. Case Hospital, Delaware. 3rd Tuesday, monthly.

(Continued on Next Page)

COUNTY SOCIETIES' OFFICERS AND MEETING DATES (Continued)

FAYETTE—H. Wm. Payton, President, 36 S. Main St., Jeffersonville; Marvin H. Roszmann, Secretary, 107 N. North St., Washington C. H. 2nd Tuesday, monthly.

FRANKLIN—James L. Henry, President, 244 E. Park St., Grove City; Mr. William Webb, Executive Secretary, 79 East State Street, Columbus 15. Meetings in January, February, March, May, September, November and December.

KNOX—Henry T. Lapp, President, 4 Public Square, Mt. Vernon; Thomas L. Bogardus, Secretary, 50 Public Square, Mt. Vernon. Quarterly meetings.

MADISON—William T. Bacon, President, 40 E. First St., London; Paul G. H. Wolber, Secretary, 40 E. First St., London. 2nd Wednesday, monthly.

MORROW—Andrew Maciurak, President, 119 E. Main St., Cardington; William S. Deffinger, Secretary, Marengo. First Tuesday, monthly.

PICKAWAY—Henry H. Swope, President, 233 N. Court St., Circleville; Edward L. Montgomery, Secretary, 108 Seyfert Ave., Circleville. 1st Friday, monthly.

ROSS—Robert E. Quinn, President, 30 N. Walnut St., Chillicothe; G. Howard Wood, Secretary, 134 W. Main St., Chillicothe. 1st Thursday, monthly.

UNION—Paul R. Zaugg, President, 130 N. Maple St., Marysville; May B. Zaugg, Secretary, 130 N. Maple St., Marysville. 2nd Tuesday, monthly.

ELEVENTH DISTRICT

ASHLAND—R. Lee Schafer, President, 203 Maple Street, Ashland; Wayne C. Smith, Secretary, 140 Claremont Ave., Ashland. 1st Friday, monthly, except July, August.

ERIE—Richard F. Hoffman, President, Providence Hospital, Sandusky; Edward P. Gillette, Jr., Secretary, 410 Columbus Ave., Sandusky. Monthly meeting date varies.

HOLMES—Clyde Bahler, President, Walnut Creek; Luther W. High, Secretary, R. F. D. 4, Millersburg. 2nd Wednesday, monthly.

HURON—Walter A. Drury, President, Box 269, Willard; John V. Emery, Secretary, Box 269, Willard. 2nd Wednesday, March, June, September and December.

LORAIN—Denis A. Radefeld, President, 209 Sixth St., Lorain; Mrs. C. Ruth Zealley, Executive Secretary, 311 Elyria Block, Elyria. 2nd Tuesday, monthly.

MEDINA—Robert E. Smith, President, 403 East Liberty St., Medina; William G. Halley, Secretary, 115 Bank Street, Lodi. 3rd Thursday, monthly.

RICHLAND—Riley E. Frush, President, 36 S. Mulberry St., Mansfield; James O. Ludwig, Secretary, 336 Sturges Ave., Mansfield. 3rd Thursday, monthly.

WAYNE—Ralph I. Cottle, President, 230 N. Market St., Wooster; Robert E. Schulz, Secretary, Wooster Community Hospital, Wooster. 2nd Wednesday, monthly.

THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

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Triaminic provides more effective therapy in respiratory allergies because it combines two antihistamines^{1,2} with a decongestant.

These antihistamines block the effect of histamine on the nasal and paranasal capillaries, preventing dilation and exudation.³ *This is not enough;* by the time the physician is called on to provide relief, histamine damage is usually present and should be counteracted.

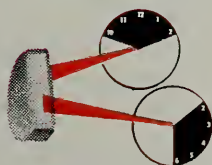
The decongestive action of orally active phenylpropanolamine helps contract the engorged capillaries, reducing congestion and bringing prompt relief from nasal stuffiness, rhinorrhea, sneezing and sinusitis.^{4,5}

TRIAMINIC is orally administered, systemically distributed and reaches *all* respiratory membranes, avoiding nose drop addiction and rebound congestion.^{6,7} TRIAMINIC can be prescribed for prompt relief in summer allergies, including hay fever.

References: 1. Sheldon, J. M.: *Postgrad. Med.* 14:465 (Dec.) 1953. 2. Hubbard, T. F. and Berger, A. J.: *Annals Allergy* p. 350 (May-June) 1950. 3. Kline, B. S.: *J. Allergy* 19:19 (Jan.) 1948. 4. Goodman, L. S. and Gilman, A.: *Pharmacol. Basis Ther.*, Macmillan, New York, 1956, p. 532. 5. Fabricant, N. D.: *E.E.N.T. Monthly* 37:460 (July) 1958. 6. Lhotka, F. M.: *Illinois M.J.* 112:259 (Dec.) 1957. 7. Farmer, D. F.: *Clin. Med.* 5:1183 (Sept.) 1958.

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TRIAMINIC provides around-the-clock freedom from hay fever and other allergic respiratory symptoms with just one tablet q. 6-8 h. because of the special timed-release design.



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The Physician's Bookshelf

(Books received from publishers. *The Journal* is not obligated to list herein every book received. It will try to list those which appear to be of greatest interest.)

* * *

Lesions of the Lower Bowel, by Raymond J. Jackman, M. D., M. S. in Proctology, Head of the Section of Proctology, Mayo Clinic, Associate Professor of Proctology, Mayo Foundation, Graduate School, University of Minnesota, Rochester, Minn. (\$15.50, pp. 349, 75 color plates, 56 sketches and photomicrographs, *Charles C. Thomas, Publisher, Springfield, Illinois.*) This is a practical guide to the clinician, being primarily concerned with diagnosis. The many excellent colored plates, photomicrographs and sketches enhance the well-written text, which very nearly approaches true conversation. An adequate section on anatomy and physiology is presented, followed by description of the technic of sigmoidoscopy, with many suggestions for the physician who does not do these examinations regularly. Many diagnostic techniques are described, including the transrectal biopsy of suspected prostatic carcinoma and other extra-rectal lesions. The author discusses the problem of polyposis, noting the similarity of incidence of polypi and carcinomata as to location and stresses the fact that approximately 70 per cent of lesions of the colon are within reach of the sigmoidoscope. The various ulcerative lesions of the bowel are described in detail, including chronic ulcerative colitis, balantidiasis, schistosomiasis, amebiasis and the sigmoidoscopic findings associated with regional enteritis. Mention is made of the granulomata of the rectum and their differential diagnosis. Very valuable to the practicing physician are the chapters dealing with transanal bleeding, anorectal incontinence, megacolon and prolapse, as well as the differential diagnosis of anorectal pain.

This book represents a definite contribution to the literature on proctology and will be of great value to the practicing physician. To quote Doctor J. Arnold Bagen, who wrote the foreword, "There are three acceptable methods of examining the rectum: One, with the trained index finger; two, with the proctoscope; and three, with the air of roentgenograms. When one views the illustrations accompanying this text, there can be little doubt as to which is the most valuable."—Robert E. Pumphrey, M. D., and J. H. Wittoesch, M. D., Dayton, Ohio.

Water and the Cycle of Life, by Joseph A. Cocannouer. (\$3.00, *The Devin-Adair Co., New York 10, N. Y.*)

Applied Medical Library Practice, by Thomas E. Keys, Catherine Kennedy and Ruth M. Tews. (\$10.75, *Charles C. Thomas Publisher, Springfield, Ill.*)

90 Days to a Better Heart, by John X. Loughran. (\$3.50, *The Devin-Adair Company, New York 10, N. Y.*)

Men, Molds, and History, by Felix Marti-Ibanez, M. D. (\$3.00, *MD Publications, Inc., New York 22, N. Y.*)

Anatomy for Surgeons, by W. Henry Hollinshead, Ph. D. (\$23.50, Volume 3, *Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers, New York 16, N. Y.*)

Essentials of Therapeutic Nutrition, by Solomon Garb, M. D. (\$2.00, *Springer Publishing Co., Inc., New York 10, N. Y.*)

Patients, Physicians and Illness, by E. Gartly Jaco. (\$7.50, *The Free Press, Glencoe, Illinois.*)

Handbook of Cardiology for Nurses, by Walter Modell, M. D., and Doris R. Schwartz, R. N. (\$4.50, Third edition, *Springer Publishing Co., New York 10, N. Y.*)

Endocrine Pathology of the Ovary, by John McLean Morris, M. D., and Robert E. Scully, M. D. (\$8.50, *The C. V. Mosby Co., St. Louis 3, Missouri.*)

Treatment in Internal Medicine, by Harold Thomas Hyman, M. D. (\$12.50, *J. B. Lippincott Co., Philadelphia 5, Pa.*)

The Birth of Normal Babies, by Lyon P. Strean, D. D. S. (\$3.95, *Twayne Publishers, Inc., New York 3, N. Y.*)

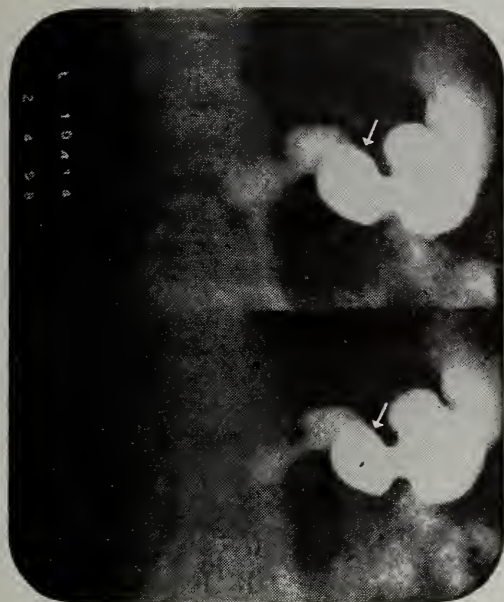
The Nutritional "Ages of Man," Nutrition: Past, Present, and Future, The Proceedings of The Borden Centennial Symposium on Nutrition. (Apply, *The Borden Company Foundation, Inc., New York 17, N. Y.*)

Vascular Surgery, by Gesa de Takats, M. D. (\$17.50, *W. B. Saunders Co., Philadelphia 5, Pa.*)

New and Nonofficial Drugs; 1959, by the A. M. A. Council on Drugs. (\$3.95, *J. B. Lippincott Company, Philadelphia 6, Pa.*)

Behavior and Physique, by R. W. Parnell, M. A., D. M. (\$7.00, *The William & Wilkins Co., Baltimore 2, Md., exclusive U. S. agents.*)

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Washington Roundup

News from the Nation's Capital of Interest to Physicians; Developments in Medical and Health Fields

AMA has reported to Congress that "solid progress" is being made in AMA campaign to improve health care of the aged. Dr. Leonard W. Larson, chairman of the Board of Trustees, reported that development of new insurance programs and expansion of existing lower cost protection for persons 65 and over are moving forward "even faster than many of us would dared hope only a few months ago."

* * *

Defense Department has stated that more physicians are graduating from medical school with a liability for military service than are needed on active duty by the armed forces, making it much easier to meet defense needs by voluntary means.

* * *

Atomic Energy Commission's dual function of developing atomic energy and determining health and safety factors involved has been questioned by a public health consultant, Dr. Russell H. Morgan, professor of radiology at Johns Hopkins University. Head of a special Public Health Service radiation advisory committee, Dr. Morgan said "there is no such thing" as a safe radiation level, despite widely accepted belief to the contrary.

* * *

Federal Aviation Agency, in new policy of stricter supervision of air safety, has made diabetes controlled with insulin, history of heart disease and psychoses disqualifiable for pilot certification. Veto power of Civil Aeronautics Board is limited to contesting accuracy of diagnoses.

* * *

Former Social Security Commissioner Charles L. Schottland has predicted passage of Federal Medical insurance legislation in the near future, contending that provision of medical benefits through social security payroll tax is feasible.

* * *

Atomic Energy Commission has approved an additional \$316,717 in grants to finance purchase of equipment for nuclear technology training in colleges as applied to life sciences. Recipients included medical schools and veterinary colleges. Latest grants bring to a total of \$1,810,707 in 152 awards to 110 institutions since program began in October, 1957.

Entire population of Virgin Islands over age 15 is being covered in a diabetes screening program being carried out by Public Health Service. Clinotron with capacity of 120 tests per hour is being used, and positives are referred to their physicians or insular health department hospitals for confirmative diagnosis.

* * *

The President has endorsed VA policy of 125,000-bed hospital capacity, but has asked for adoption of "a clear policy governing the role of the Federal government" in providing veterans care facilities. In January, 1959, VA average daily patient load was 115,195, 66 per cent of those being non-service-connected cases.

* * *

HEW Secretary Flemming has announced first successful field trial of fluorescent antibody technique in rapid identification of rabies virus in animals. Trial consisted of 144 suspected cases put to new test, which consumes only a few minutes. Comparison of results with standard rabies test with mice, which takes two to three weeks, produced 100 per cent agreement.

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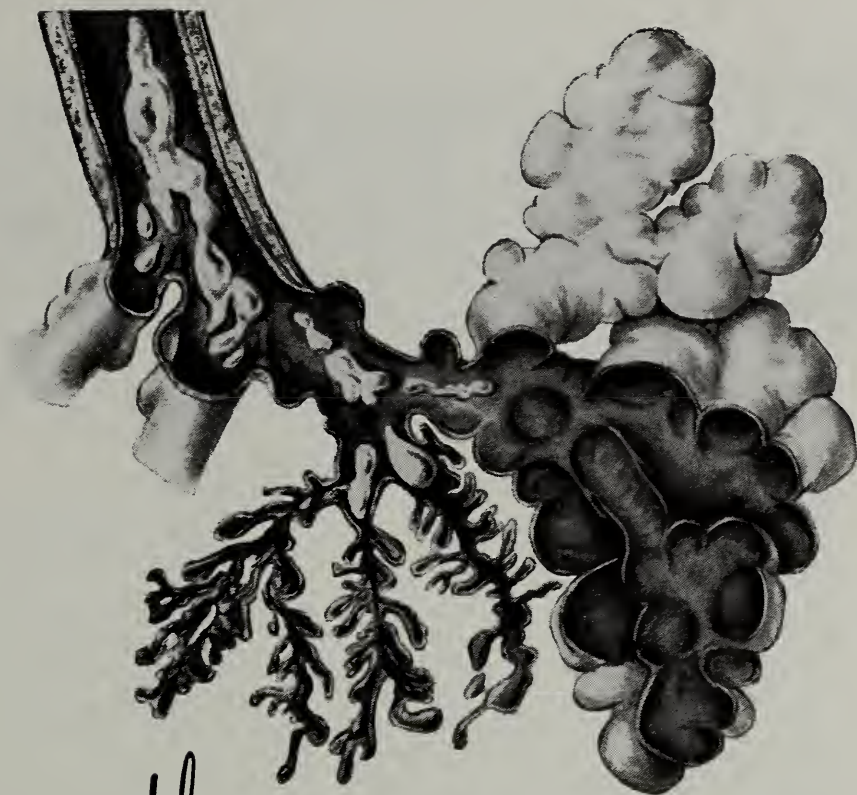
First woman physician to be honored in Statuary Hall is the late Dr. Florence Sabin of Colorado, noted medical researcher and in her later years a public health leader in Colorado. At the unveiling ceremonies in the Capitol, Dr. George Fister of the AMA Board of Trustees represented the association.

* * *

National Cancer Institute studies indicate incidence of a number of specific forms of cancer may be associated with socio-economic status. Most consistent relationship observed in a study of 10 metropolitan areas was a relatively high incidence rate of cancer of the upper alimentary tract, pancreas, respiratory system and uterine cervix among the lowest one-third income group.

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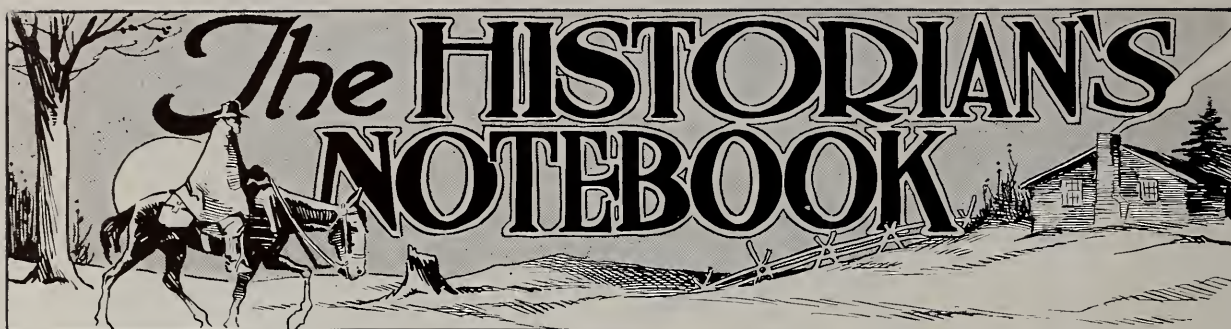
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Going to the Healtheries

BRUNO GEBHARD, M. D.

HEALTH FAIRS, or as they were called in the last century, "Sanitary Fairs," are having a revival in many American communities. One of the earliest sanitary fairs held in this country took place in Cincinnati in 1862. It was conceived and directed by General W. S. Rosecrans "to call attention to the insanitary conditions of the towns and to point out the measures by which communicable diseases could be prevented." This was before the bacteriologic era in public health, and the remedy was thought to be mainly in cleaning up the environment. But the sanitary fairs had little educational value. They were, more or less, money-raising affairs, the benefits going to the Sanitary Commissions of the Civil War. The "Great Western Sanitary Fair of Cincinnati" reported the receipt of not less than \$260,000.¹

Anniversaries of professional medical organizations are sometimes the stimulus for putting on a health fair for the public as was done so successfully by the Cincinnati Academy of Medicine for the 1957 Centennial celebration. The Columbus Academy of Medicine organized a Health Fair (March 24-29, 1959) where numerous local exhibits were supplemented by those from the American Medical Association, and the Cleveland Health Museum. The Dominican Republic made available a copy of the "Transparent Woman" which originated at the German Health Museum in Cologne.

England, as a motherland of the sanitary movement is also the originator of health fairs for the public. The Great Exhibition of 1851, better known as the Crystal Palace Exposition, had little to show as far as medicine and public health were concerned. Of the 742 items listed in Class 10 "Philosophical, Musical, Horological, and Surgical Instruments," not even three dozen were surgical, as a medico-chirurgical ambulance, a medical walking staff containing instruments and medicines,

The Author

● Dr. Gebhard, Cleveland, is Director, Cleveland Health Museum.

artificial teeth, carved from hippopotamus ivory, a duplicate stethoscope made of gutta-percha as a real novelty.

The "authentic voice of the new hygiene" made itself seen by a "model lodging house" to accommodate four families, presented by the "Society for Improving the Dwellings of the Laboring Classes" but paid for by the Prince Consort, the President of the Society.

U. S. A. contributions were meager and poor. Early models of sewing machines competed successfully with an air-supported coffin intended to preserve the dead from putrefaction. The American section showed a leftover from the medieval museums, a prize piece of their magical collections, treasured for being a preservative against poisoning, or producing perspiration against fever, whatever the situation demanded, the horn of a unicorn.

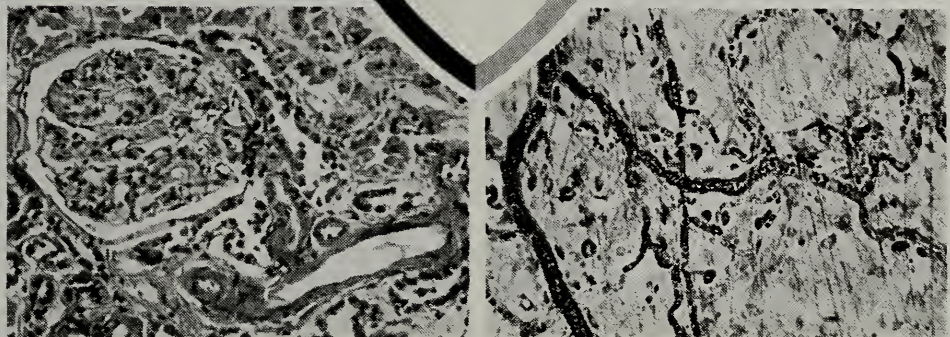
Ohio Exhibits at Crystal Palace, 1851

There are quite a number of items listed from Ohio, the majority being from Cincinnati and Zanesville, Newark, Steubenville, and one item from Cleveland. They range from lightning rods, points and insulations, specimens of Indian corn, artificial teeth on an improved principle, specimen of catawba wine, compound microscope, brushes, brooms and whisks, improved bank lock, specimen of beef tallow and lard. The Ohio State Board of Agriculture had detailed exhibits including a case of specimens illustrative of the economic geology of Ohio, and a buck-eyed squirrel (stuffed) was an exhibit by Mr. W. A. Moyston of Columbus. Mr. R. Thompson from Columbus, Ohio, presented a Plough, Surgical Instruments and

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Dosage: 2 to 6 tablets daily in divided doses initially; may be adjusted within range of 1 to 6 tablets daily in divided doses. **Note:** In hypertensive patients already on ganglionic blocking agents, veratrum and/or hydralazine, the addition of Rautrax necessitates an immediate dosage reduction of these agents by at least 50%. A similar reduction is necessary when these agents are added to the Rautrax regimen.

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The advertising pages of the Official Catalogue² gives a good cross section of the favored patent medicines of those days, mainly fluid magnesia, pulmonic and antibilious wafers, Herbal Embrocations for the Hooping Cough. An advertisement with a beautiful woodcut asks for voluntary contributions to the Seamen's Hospital on board of the "Dreadnought." Madame Tussaud and Sons invite visitors to see her Historical Gallery, celebrating its 50th anniversary.

Health education, by exhibits, had its first big show at the International Hygiene Exposition in Brussels, 1875. Main subjects were those of low-cost housing, general sanitary improvements, central water supplies which, after all, are the prerequisite for centralized sewage disposal, and a growing interest in all questions of the health of the school child. Education for everybody was one of the slogans of a beginning scientific approach to social problems.

Health education in Europe was part of the many social improvement actions, a movement which started in the United States only by the end of the last century.

The reduction of mortality of children under 15 years old was specially fostered by the National Association for the Promotion of Social Sciences. The British Medical Association was actively encouraging the establishment of Boards of Health, and was leading in securing medical men as local health officers. The first museum of hygiene was established in 1877, named after Dr. E. A. Parkes, in connection with the Royal Sanitary Institute.

Four Million Visitors at the London "Healtheries," 1884

Florence Nightingale, who was not just the sweet lady with the lamp but quite a fighting soul in the field of public health politics, wrote, in a charming letter December 31, 1884, to Mr. E. White Wallis, the secretary of the Institute, "I was sorry that owing to business and illness I was too late in sending in my name for the petition to the Healtheries." She was referring to the International Health Exposition of that year. Nearly four million Britishers had visited this Exposition in London on weekdays, from May to October, as, according to the Sabbath rules of those days, the gates were closed on Sundays.

International hygiene expositions were quite the fashion in those days. The London Exposition had taken many of its popular features from one

held the previous year at Berlin, with Robert Koch as the guiding genius. Special laboratories demonstrated for the first time, by Koch and his assistants, the cultivation of the deathful germs, but the Munich School of Pettenkofer was presented with many exhibits showing the relationship of health and disease to the physical and chemical conditions of the soil, air and water.

The London Exposition, both in scope and in attendance, has never been surpassed in England. John Shaw Billings was a visitor and praised it highly, especially what was called the "Health Laboratories," and also another one, under the directorship of Francis Galton (father of Eugenics) which demonstrated how progress in growth and development can be measured; in some way, they were the forerunner of our annual health examinations.

"Going to the Healtheries" had become a new coined word in London as an expression of the popularity of the exhibition grounds where, as a year before, a very popular fishery exhibit took place and was commonly referred to as "The Fisheries."

From Dresden Hygiene Exposition, 1911 To Cleveland Health Museum, 1936

It was in Dresden in 1911, at the International Hygiene Exposition, where human biology was made the center of a public health education exposition. Eleven million visitors came from many parts of the world and there is a very interesting report by Henry G. Beyer, M. D., the Medical Director of the United States Navy of this Exhibition.³

World War I interrupted an organized development of health fairs and health museums, and as the Victorian Age, which shied away from many things connected with the human body, lingered on longer in the United States than in Europe, very little activity went on in the line of popular health education by either fairs, or museums. The beginning of a new era was started out by the American Medical Association in the Middle Twenties, under Tom Hall, Ph. D., and reached its first peak at the Chicago Century of Progress Medical Science Exhibits, which were developed by the late E. J. Carey. The Great Lakeside Exposition in Cleveland in 1936 and 1937 laid the groundwork for the establishment of the Cleveland Health Museum as the first one in the nation.

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PERRY R. AYRES, M. D., *Editor*

CHARLES S. NELSON,
Managing Editor — Bus. Mgr.

R. GORDON MOORE,
Asst. Managing Editor

Planning Community Programs for Cerebral Palsy Patients

JOHN P. RIEPENHOFF, M. D., ERNEST W. JOHNSON, M. D., and PAUL R. MILLER, M. D.

IT IS BASIC to any cerebral palsy program to recognize that a child with this condition has multiple handicaps and, therefore, no single discipline of medicine can provide for the child's total needs.¹

In the management of the cerebral palsy patient, it is obvious that a comprehensive approach should be utilized. This approach should include four general concepts; (1) adequate diagnosis with proper emphasis on every handicap, (2) direction in management after a complete evaluation, (3) interpretation and counseling to the parents, and (4) coordination of the existing facilities for the treatment of the cerebral palsied.

This paper will endeavor to define the process by which such a program was formed in Columbus and Franklin County in the state of Ohio. Furthermore, this program could serve as a guide to communities having similar problems.

History of the Program

It has been apparent for some time that there is a necessity to coordinate the various cerebral palsy services in many communities.

In Columbus, Ohio, as in other cities, more than one cerebral palsy facility has been in operation, each acting more or less independently. Not only did some rivalries exist, but it was suspected that there was overlapping in the services as well as a deficiency in the medical aspects of some of the programs. Early in 1956 a joint committee was established by the Columbus Academy of

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Medicine and the Metropolitan Health Council to (1) study existing services for cerebral palsy in the community and assess present needs in this field, (2) plan means of coordinating the above services in order to insure more efficient care, and (3) plan long term objectives for efficient and well directed services for the cerebral palsy patient.²

From this study it was found that the various agencies caring for children with cerebral palsy were, for the most part, giving acceptable service within the limits of their equipment and personnel. In spite of the number of agencies involved, each was providing its own special service and

dealing with selected groups so that duplication of effort was far less than appeared on the surface.

There were, however, two major deficiencies: (1) inadequate medical diagnosis and supervision, and (2) incomplete records and follow-up. The first of these deficiencies was thought to be due to the fault neither of the agencies nor of the individual physicians who served them, but rather an inherent defect in our medical education and practice. Experience has shown that no one physician is competent to deal authoritatively with all of the problems presented by a

Editor's Note:

This article should be looked upon as a progress report on good citizenship.

The neurologic evaluation service described here was the outgrowth of an exceedingly detailed study of the problems surrounding cerebral palsy in the Columbus Metropolitan Community. The study brought order out of a complex and confusing situation and helped to clear up misunderstanding among some 17 organizations contributing to the care of people with diseases classified as cerebral palsy.

Everyone concerned with the study and with the implementation of its recommendations should read this report with pride. The Joint Committee reported excellent co-operation from both lay and professional personnel in every phase of this endeavor.

Accomplishments of the sort described here certainly reflect a spirit of cooperation and devotion to the common good consistent with the best American tradition.

cerebral palsy child. The second finding of incomplete records contributed to inadequate supervision and follow-up of the patient. In many cases the program was not adjusted to the patient's progress and treatment was continued beyond reasonable expectation of improvement.

The findings of the joint committee led to two important recommendations to improve services for cerebral palsy in Franklin County. These were: (1) to organize a central evaluation service consisting of the various medical and allied specialists necessary to completely evaluate all of the possible handicaps of the cerebral palsy patient, and (2) to establish a coordinating committee to function as a community planning and integrating agency for cerebral palsy services.

In accordance with the recommendation to establish an evaluation service, the Columbus

Children's Hospital accepted the authority and responsibility to provide such a facility.

History of the Service

In 1956 a committee of physicians from the staff of Children's Hospital was appointed to develop and plan the evaluation service. The original planning was initiated in February, 1956, and the evaluation service began receiving patients in October, 1957. This committee of physicians enthusiastically agreed with the concept of total evaluation of cerebral palsy requiring a team approach using the several different disciplines of medicine as well as the various medical ancillary services.

It was the opinion of the planning committee that such a comprehensive study of a patient is only possible and practical when the patient is admitted to the hospital where he is available for all necessary examinations and tests. This committee of physicians then developed the organization and the operational plan of the evaluation service which is currently in effect.

Description of Service

Patients are referred to the evaluation service only by physicians who follow the usual procedure for hospital admission. A pre-admission interview of the parents by the hospital social worker is necessary to obtain information needed by the medical staff to understand the parents, the child and his environment. During the interview consideration is given to the amount of time the parent should be with the child during the hospital stay.

The patient usually is admitted to the hospital for three to five days. During this time he is examined by each member of a team of medical specialists consisting of a pediatrician, neurosurgeon, ophthalmologist, orthopedist, physiatrist, dentist, psychiatrist, and the child developmentalist. Physicians in the various specialties represented in the evaluation service are rotated through the service each quarter. These physicians are taken from a list of those who have indicated their wish to serve on the evaluation team.

In addition, the child is evaluated by a physical therapist, occupational therapist, a speech pathologist, an audiologist, and a psychologist. The routine laboratory examinations include an electroencephalogram, roentgenograms of the chest, skull and spine, a complete blood count, urinalysis, serologic test for syphilis, and urine for phenylpyruvic acid. When indicated, additional studies include electromyogram, myelogram, and air encephalograms.

The staff meets weekly to discuss diagnosis and

management of each patient. The final goals of the evaluation are as follows:

1. To determine as accurately as possible every aspect of each individual's disability.
2. To plan a course of management for each patient.
3. To help the parents better understand the child's handicaps.
4. To provide a complete summary of the medical records together with recommendations for management to the referring physicians as well as the appropriate treatment facilities.

At present the evaluation service does not participate in any follow-up management for the patient. One of its main functions, however, is to assist in making the necessary arrangements for the individual patient to receive therapy elsewhere.

After the staff conference the parents are called for consultation with the staff pediatrician. If possible, the referring physician is encouraged to attend this conference as well as the regular staff conference. Interpretation of the findings of the evaluation service is made to the parents in an attempt to give them an understanding of the direction of future management.

A complete medical report including findings and recommendations is then forwarded to the referring physician. Should there be no family physician, the staff pediatrician refers the patient to a physician or clinic in the family's locality. Frequently, the evaluation staff recommends a re-evaluation after an appropriate interval.

The Coordinating Committee

The coordinating committee consists of two representatives from each of the agencies in Franklin County providing services for disabled individuals. The director of the evaluation service is also a member of the committee. This group is governed by a constitution and bylaws and each member has an equal vote at the monthly meeting.

This committee has the responsibility of assisting in financing the evaluation service by providing grant-in-aid to parents who are unable to pay for the cost of the service. Funds are made available to them by their respective organizations.

Another purpose of the committee is to coordinate the activities of the various facilities in the community serving the handicapped child. This organization provides the means for dissemination of information concerning the cerebral palsy evaluation service to agencies which may refer patients or receive them for treatment. The

committee also offers guidance for future community planning of services for cerebral palsied persons.

Value of Service

Teaching. This service has provided the staff with a mutual educational experience. Physicians have developed a better understanding of the classification of cerebral palsy and the part each specialty plays in its diagnosis and management. The service also has provided a wealth of clinical material for the house officer, medical student and students of ancillary services and demonstrates the value of a comprehensive approach to a complicated condition.

Such an approach tends to alert the physician in the community to the resources available. In the past, many cerebral palsy patients have been seen by physicians but are unknown to any cerebral palsy facility. Such a service also tends to educate the lay members of the community, giving them a better understanding of the problem, and stimulating them to seek out proper treatment facilities.

Awareness of Associated Handicaps. For many years the emphasis has been on the motor deficit in cerebral palsy. As has already been stated, patients with cerebral palsy have multiple associated defects, any one of which is no less important than the motor deficit. Indeed, in many cases, the associated defect may be more incapacitating than the motor handicap. Parents have been all too conscious of braces and exercises and have neglected the other aspects of the child's difficulty such as emotional state, speech problem, visual and auditory handicaps, sensory deficit and seizures as well as the most important, intellectual potential.

It is the policy of this service to emphasize the associated defects and direct as much of the management as possible to their correction or alleviation.

Base Line for Programing. The comprehensive diagnostic study on each patient forms a basis for follow-up studies and direction in long term planning.

Parental Counseling. The evaluation service gives the parents two major benefits. First, the parents can feel that the child has received an authoritative and thorough analysis. Second, by virtue of their conference with the staff pediatrician, the parents receive an interpretation and consequently gain increased understanding of their child. The parents then may react more realistically to the program developed for their child and their role in this program. Since the parent ultimately is responsible for much of the patient's treatment at home, it is helpful that he realize the

child's limitations on one hand and his assets on the other.

Integration of the Cerebral Palsy Service in the Community. This service complements the existing facilities in the community. Many new otherwise untreated, cerebral palsy patients are disclosed by the evaluation service and ultimately referred to various treatment facilities for follow-up care. In this manner the service acts in case finding. On the other hand, the evaluation service also lends valuable assistance to the cerebral palsy treatment centers when patients are referred by them to the service for further diagnostic study and as a source of authority for termination of therapy.

Many cerebral palsy treatment facilities find it difficult to discharge a child from their care when the child is showing no further response to treatment. The parents, likewise, find it difficult to accept this decision and in many cases become antagonistic because they feel their child has not been given a fair chance. The impartial opinion of the evaluation service, therefore, serves to reinforce the individual facility's decision to terminate treatment. In many cases, a new direction for management is discovered.

Discussion

The psychologic impact of the diagnosis of cerebral palsy with all its implications on a family is inestimable. A rapid, intensive, concentrated effort to complete all of the medical and laboratory examinations within the shortest possible time lessens this effect. Such a comprehensive study is only possible and practicable when a patient is hospitalized. The patient is then readily available for the necessary laboratory studies and medical examinations. Inpatient observation also provides the staff with information concerning the behavior of the child during all times of the day as well as an opportunity to observe his activities of daily living. Furthermore, the evaluation team can work together at a given time to retest, exchange opinions and verify important findings.

One of the most important aspects of the management of cerebral palsy is the need for a well outlined home program. Every patient, regardless of the severity of the disability, needs to have a simple well defined home program. This may be merely instructions for motor environmental stimulation regularly during the day. Occasionally, such as exercises and training in activities of daily living. It has been our experience that parents, in general, reject the diagnosis of cerebral palsy unless allowed to "do something" to help the child. This home program provides an excellent

medium for the parents to come to understand the child's disabilities and capabilities. This can do much to promote the parents' acceptance of their child's handicap especially when supplemented by participation in parent counseling groups.

As a central evaluation service, we are in the unique position to refer our patients to more than one cerebral palsy or other treatment facility simultaneously. As has already been stated, the existing cerebral palsy agencies offer very little overlapping of service in our community and yet no one facility is able to offer a complete program. Interaction of services requires close communication and cooperation between the various facilities. The evaluation service and the coordinating committee have served to promote this concept.

Summary

The background, organization and operation of a cerebral palsy evaluation service is described. The value of such a service to the patient, to the staff and to the community is mentioned. Some trends in the direction of management of this multiple handicapping condition are suggested.

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Group A Beta Hemolytic Streptococci And Rheumatic Fever

The etiologic relationship reported to exist between group A beta hemolytic streptococci and rheumatic fever may be influenced profoundly by factors other than the mere presence of the indicated organisms. . . .

An intensive baseline investigation of group A beta hemolytic streptococci isolated from the throats of children six to nine years of age, was carried out in three public schools in Miami, Florida, by means of monthly throat culturing of 333 children during the school year, October 1954 to May 1955. . . . There was a small, but definite, decrease in the streptococcal recovery rate with advancing age, in six to nine year old children. Group A streptococci were isolated from the throats of six to seven year old boys more frequently than girls; the proportion of boys to girls, ages seven to eight, harboring these organisms, was approximately equal; in eight to nine year old children, girls' throats were positive for streptococci much oftener than boys'.—Milton S. Saslaw, M. D., and Murray M. Streitfeld, Ph. D., Miami, Fla.: *Dis. of Chest.*, 35:175, February, 1959.

Carcinoma of the Colon and Rectum in Children*

M. TISCHER HOERNER, M. D.

THERE is increasing evidence to show that age is no barrier to the occurrence of carcinoma of the colon and rectum in young individuals. It has been generally appreciated that sarcomas are rather common in children, but epithelial malignant growths have been found in sufficient instances to warrant their consideration in a differential diagnosis of childhood diseases.

A recent review of the literature⁶ has shown that there are already on record 189 cases of carcinoma of the rectum and 73 instances of malignant disease of the colon in patients under 20 years of age. The patients in this age group reported in the literature suggest that the ratio between cancerous growths in the rectum and the rectosigmoid and those situated at higher levels of the large bowel should be approximately 2.5 to 1.

Pathology

Malignant epithelial tumors of the large intestine are usually one of three types of lesions: (1) adenocarcinoma is probably the most common; (2) scirrhous carcinoma is the type that is seen so frequently in left-sided colon lesions and is responsible for the development of obstructive phenomena; (3) mucoid adenocarcinoma or mucoid carcinoma constitutes about 5 per cent of all neoplasms of the colon and rectum in adults. It is interesting to note that in children mucoid carcinoma is found in 50 per cent of the patients having malignant disease of the large intestine.

Sarcomatous growths of the large intestine are reported occasionally. However, a survey of the literature suggests that epithelial tumors of the large intestine are more common in young individuals. Bonelli believes that quite the opposite is true as far as the small intestine is concerned. He found 63 cases of sarcoma of the small intestine with 77.6 per cent of the lesions being located in the ileum. There were only 12 instances of malignant epithelial disease of the upper intestinal tract.

Signs and Symptoms

The symptoms of carcinoma of the colon in children are not specific. Probably because of the nature of the nerve supply of the large intestine and by virtue of its size, as to width of lumen, as well as territory in the abdomen cov-

The Author

● Dr. Hoerner, Dayton, is Senior Surgeon, St. Elizabeth Hospital; Senior Consultant of Surgical Service, Miami Valley Hospital.

ered, pain when present often is not at the site of the lesion. This is especially true of the so-called "silent" right colon, for symptoms frequently are not noted until considerable alteration in structure or function has occurred.

The pain associated with a lesion in the right colon is frequently referred to the epigastrium. The pain or distress may be cramp-like or aching in character. The mild dyspepsia that is sometimes seen in association with recurrent appendicitis is also sometimes observed in these patients. There are reports in the literature² where the patient was operated upon for appendicitis and the appendix was not found to be causing the illness. Subsequently, the etiology of the pain was discovered to be carcinoma of the colon.

Such observations emphasize the importance of making a thorough exploration of the abdomen before closure of the wound, when a child is operated upon for chronic, recurring attacks of abdominal pain and the cause is not apparent. Instead of explaining the abdominal pain or enlargement of the mesenteric lymph nodes on the basis of mesenteric adenitis, consideration should always be given to the possibility of the presence of carcinoma of the colon in children.

Not infrequently the first sign of disease of the right colon will be the accidental discovery of a mass in this area. Due to the size of the lumen of the bowel, the tumor may reach considerable proportions before producing symptoms.

Anemia is another cardinal sign of malignant disease of the right colon. It may vary from a mild secondary anemia to an anemia so profound that the patient is unable to be as active as formerly.

In contradistinction to malignant growth in the right colon, those on the left in children often afford more evidence of their location. Obstruction is the outstanding characteristic of lesions in this side of the colon. There may be alternating constipation with abdominal cramping and urgency,

*Read before Ohio Chapter, American College of Surgeons, September 5, 1958, Dayton.

and diarrhea with blood in the stool. However, obstruction is not uncommonly complete during the first attack in children and it may be the initial indication that there is something wrong in the colon.

Treatment

The treatment of choice for all malignant lesions of the large intestine in children is radical resection of the growth and restoration of the continuity of the bowel by immediate anastomosis. The incidence of high grade malignancy and the frequency with which early metastasis is discovered in children with carcinoma of the large intestine, make extensive resection an essential feature in the treatment of the condition. Resection and primary anastomosis in the presence of marked obstruction is contraindicated. Consequently, there are instances where decompression of the bowel is essential and a two-stage operation is a life saving and proper procedure.

Comment

The prognosis of carcinoma of the colon and rectum in children is not good. The longest periods of survival of young people afflicted with this disease found in the literature are the cases of Webster, Scholefield, and Hoerner.⁶ Webster reported a patient who lived four years after operation and Scholefield a youth who showed no demonstrable recurrence seven years after surgery was performed. The author has reported elsewhere a boy 18 years of age who has lived eight years after resection of a malignant growth in the colon. This constitutes possibly the longest survival on record. When one has to resort to reporting success in the treatment of individual patients, it emphasizes the fact that the therapy administered to most individuals suffering from this disease leaves much to be desired.

One reason for the poor prognosis is due to failure to diagnose and treat children with neoplasms of the bowel early. Many men do not appreciate that malignancy of the colon can occur at an early age. The youngest patient with this disease reported in the literature was three years and three months old. Many of the patients operated upon were not properly prepared for surgery of the colon because the preoperative diagnosis was often appendicitis, tuberculous peritonitis, or acute intestinal obstruction.

The fact that the symptoms of this condition in children are of relatively short duration adds to the difficulty of making an early diagnosis. It is well known that there is an increased incidence of early metastasis associated with the high grade malignancies so frequently seen in tumors of the

large intestine in children. Until more reliable methods are suggested, careful consideration must be given to the milder complaints associated with disturbances of the intestine. It is only by being alert to the possibility of the presence of carcinoma of the colon in children that an early diagnosis can be made. An early diagnosis is essential if we hope to salvage more of these patients.

So far we have considered only the highly malignant primary carcinomas of the large intestine in children. Mention should be made, however, of a second group of malignant lesions composed of those instances in which an adenomatous polyp of the colon undergoes malignant transformation. These lesions can be treated conservatively and prophylactically. Benign polyps of the bowel often bleed before malignancy develops. Whenever bleeding from the rectum occurs in children, a thorough search should be made for the cause. The removal of a benign polyp may prevent the development of a serious malignant disease of the bowel. Furthermore, it has been demonstrated that carcinoma of the large intestine in adult life can be due to malignant changes in polyps which manifested themselves in infancy or childhood.

Summary

Age is no barrier to the occurrence of carcinoma of the colon and rectum in children. To date 189 cases of carcinoma of the rectum and 73 instances of malignant disease of the colon in patients under 20 years of age are recorded in the literature.

Carcinomas of the right side of the colon in children do not tend to produce obstruction as do malignant lesions involving the left side of the large intestine.

The prognosis of carcinoma of the colon in children is poor. This is due to failure to diagnose and treat the condition early and because the lesions tend to be highly malignant and metastasize quickly. Early, radical resection of these growths offers the only hope for salvage of these young individuals. Removal of benign polyps of the colon may prevent the development of malignant transformation during childhood or adult life.

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Complications in Anorectal Surgery*

(Consideration of Certain Problems with Emphasis upon Means of Prevention)

W. H. HAMILTON, M.D., E. B. HAMILTON, M.D., and C. H. HAMILTON, M.D.

SURGICAL disease of the anorectal region is common. It provides a major portion of the surgeon's practice. There is no more grateful patient than one who has received relief from symptoms of anorectal disease, whether the condition is hemorrhoids, fissure or fistula. On the other hand, there is no one more miserable than the patient who has been subjected to rectal surgery and has been abandoned with a bad result.

All too often anorectal surgery is undertaken as a minor procedure without regard for the final result. A noted surgeon once said, "Minor surgery is surgery performed by minor surgeons." Certainly to the patient being operated upon the surgery is quite major.

The material in this paper comes from 30 years of experience by the senior author; it represents some 5,000 operative cases. It is our hope that by emphasizing certain valuable principles we may help to minimize the number of poor results and limit the morbidity in proctologic surgery.

I. Preoperative Considerations

Let us first consider the problems that face the surgeon prior to surgery. The utmost discretion must be used in selecting the best time for surgery. The diagnostic evaluation must be thorough so that other significant disease is not permitted to go unrecognized. Pontius et al.⁴ have stressed the importance of ruling out or correcting other disease in the colon such as amebiasis or ulcerative colitis. In cases where bleeding is a primary symptom, latent sources such as polyps, diverticulosis, and carcinoma must be eliminated.

In general, definitive rectal surgery should not be performed in the face of acute or weeping perianal dermatitis. The surgeon should make a thorough investigation of the lower urinary tract where past history indicates disease may lie. He should pay particular attention to the prostate gland in males and the bladder and urethra in both sexes to preclude postoperative urine retention. Symptomatic pulmonary disease must be ameliorated and smoking limited in certain patients before surgery to prohibit explosive paroxysms of coughing in the recovery period. Generally any significant degree of pelvic floor relaxa-

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tion in females should be treated before correction of anorectal disease.

II. Problems Associated with the Early Postoperative Period

A. Pain.

Following anorectal surgery most patients have severe pain. The key to pain control is to administer narcotics in adequate doses before pain perception reaches its peak. If medication is withheld too long in the immediate postoperative period, the sphincter musculature becomes spastic and markedly larger doses of analgesics are needed. Such spasm also results in tissue ischemia, edema, and delayed wound healing due to less effective drainage. We have found some nurses reluctant to administer narcotics to these patients when they are ordered for "as required." So we have established a routine of a regular dosage schedule in the first 24 to 48 hours. This has given satisfactory results. The drugs may then be reordered on an "as necessary" basis. We have found that early and frequent application of moist heat in the form of mild astringent compresses affords relief until regular sitz baths can be started.

Trimpi and Kratzer² have studied the comparative analgesic effects of selected narcotics in patients following hemorrhoidectomy. Their work is well controlled; it demonstrates the side effects which may be expected with each drug. Some surgeons are enthusiastic about long-acting local anesthetics for pain control. However, most authorities have reported serious complications fol-

*This paper is a sequel to one presented at the annual meeting of The American Proctologic Society in New Orleans, April 24-27, 1957. (See References: No. 3)

lowing the use of the agents. The various topical "cain" preparations have been notorious in their tendency to sensitize or cause local contact dermatitic eruptions. Therefore it is best to omit them.

B. Bleeding

Bleeding in the postoperative period may be early (within 48 hours), late (10 to 14 days postoperative) or delayed (six weeks or more after surgery). The first two categories are related to the surgical procedure. Bleeding several weeks after surgery may mean that a thorough evaluation of the colon was not made before surgery.

Early bleeding is usually due to inadequate ligation of arterial vessels either at the level of the internal plexus or in the sphincter muscle dissection area. In the operative treatment of hemorrhoids we routinely use a figure-of-eight high ligation suture to control the arterial supply to the segment prior to dissection. In addition we have found the superficial contact cautery knife of exceptional value in keeping the surgical field clear of troublesome oozing. This permits accurate clamping and ligation of active bleeders. Venous oozing will usually respond to pressure but it is best never to terminate the operation until hemostasis is completed.

Late bleeding can usually be attributed to an area of slough with vessel erosion where tissues were sutured under too much tension. Occasionally bleeding at this stage may be caused by passage of a large constipated stool. This tears the healing anal canal. Careful bowel regulation will avert this problem. Persistent bleeding from the rectum after the usual healing period of six weeks can only mean that a bleeding source in the upper rectum or colon has been missed in the preoperative investigation.

C. Urinary Retention

Next to pain control, retention of urine is probably the most frequent problem following anorectal surgery. The explanation for it is not always clear, but there are undoubtedly many factors involved. Some patients are able to void without difficulty despite the type of anesthetic used and regardless of the operative procedure performed. Others require catheter drainage for the first day or two.

Emmet and Christol⁵ explain that the external anal sphincter and the external urethral sphincter are both supplied by the pudic nerve. They base the problem of urinary retention on reflex spasm in the urethral sphincter caused by primary anal sphincter spasm. This again stresses the importance of controlling anal sphincter spasm. Certainly patients should not be routinely catheterized

following proctologic surgery. Those who cannot void within eight to twelve hours and who demonstrate bladder fullness must be catheterized under aseptic conditions without delay. Adequate chemoprophylaxis should be started at that time.

In patients who have known partial obstruction of the lower urinary tract or in those who require extensive rectoplasties, it is best to place an indwelling catheter at the time of surgery. This is much preferred to multiple catheterizations since each carries the potential danger of infection. In most cases the catheter may be removed in 48 to 72 hours. In more complicated cases urologic consultation should be called without hesitation.

III. Late Complications

A. Incontinence

Fortunately incontinence does not occur often. But when this tragedy follows rectal surgery the surgeon is truly confronted with a formidable challenge. The simple fact is that effective methods of correction are limited. Therefore means of prevention should be stressed and re-emphasized frequently.

During fistulectomy or fistulotomy for deeply located tracts, an attempt should be made to repair the muscle division sites loosely so that wide retraction does not occur. This may be done after locating the internal opening. In most cases with adequate dissection the mucosa can be replaced over the muscle without fearing recurrence of the tract. In patients with marked hemorrhoidal prolapse there is associated sphincter muscle ptosis due to inflammatory adhesions between the plexus and muscle. These adhesions may be lysed during dissection and the sphincter muscle replaced at its normal level. This largely restores the patient's full continence. The clamp and cautery method is not used as much now as it was. Those that use it must employ great care so as not to injure the sphincter muscle.

Chemical agents and solutions used for prolonged local anesthesia or for sclerosing hemorrhoidal plexuses should be administered with great care. Extensive necrosis has been reported with resultant irreparable muscle damage. The one indication for use of sclerosing materials in proctology is for injection treatment of the single, internal bleeding hemorrhoid.

Finally, patients should be selected for operative treatment with care. The surgeon must recognize which patients he can benefit by surgery; he must decline the remainder. He must recognize the deceptive etiology of some cases of relative incontinence such as is seen in lues, cerebral disorders, and spinal cord degeneration of various types. If these are noted, surgery will not be per-

formed and then be mistakenly blamed for an undesirable result.

B. Stricture

Stricture formation is not an uncommon sequel of anorectal surgery. The proctologist usually inherits patients with this complication on a referral basis. Therefore he is more aware of their frequency.

The majority of strictures occur for two reasons. First, the surgeon removes too much tissue. Second, the surgeon either does not or cannot give enough diligent postoperative care. In a previous paper³ we stressed the importance of conserving a necessary amount of the valuable lining substance of the low rectum and anal canal. Enough mucosa and skin must be removed to provide the patient symptomatic relief, but not enough to cause stricture. In this sense proctologic surgery is plastic and reconstructive as opposed to destructive.

Dissection should be accomplished in radial lines, always leaving adequate islands of mucosa and skin to prevent excessive scarring. In acute cases of prolapse with thrombosis and marked edema, it is quite tempting to remove all of the swollen tissue. But this cannot be done or stricture will frequently result. The amount of edema and extent of sphincter muscle ptosis must be considered before deciding how much tissue can be sacrificed. It is imperative to establish adequate drainage channels at surgery. This will minimize edema and pain postoperatively and promote more rapid healing with less scarring of the operative site.

These patients must be followed closely while in the hospital and checked frequently after discharge for a six week period. This may not be possible in all cases. If the surgeon cannot follow the patient himself, usually some qualified physician can be found to help the individual accomplish the simple but important measures required. While in the hospital the operative site must be checked daily for maintenance of drainage and wound cleanliness.

Bowel activity must be regulated so that a solid yet unconstipated stool is passed without excessive pain or bleeding. Gentle digital dilation on the fourth or fifth postoperative day is performed to separate any approximation of wound edges or thin tissue bridges. The patient may be taught to insert his own finger with a well lubricated glove or finger cot to gently massage the anal canal. This should be done every few days. It usually is best after a sitz bath, between visits to the doctor's office.

Swinton¹ reports that the rate of stricture forma-

tion following proctologic surgery at the Lahey Clinic is minimal in those patients who can be adequately followed for the usual six week healing period.

C. Recurrence of Disease

If carefully evaluated most cases of "recurrent" hemorrhoids, fistula-in-ano and fissure are found to be the result of inadequate surgery. Here again the plastic nature of proctologic surgery is demonstrated. Enough tissue must be removed from the correct locations to cure hemorrhoids. Not too much tissue can be removed from the internal anal circumference or stricture and ulcer formation occur. Deep multiple-plane fistulous tracts can be a great challenge to the surgeon. Nevertheless if they are traced to their origins and unroofed, followed by appropriate mucosal repair and satisfactory external drainage, the cure is obtained. The practice of rectal surgery should definitely not be undertaken lightly or by the uninitiated.

The other aspect of recurrent anorectal disease depends on the patient's cooperation with the doctor in regard to bowel hygiene. If the patient is willing and can be taught the importance of proper hygiene, seldom will a problem develop after the corrective surgery. Attention to diet, bowel regulation, sufficient hydration and reasonable local perianal care during and after stool will make symptom recurrence a rare event.

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Knee Pain Often Referred From the Hip Joint

The failure to recognize and treat hip disease early, particularly in children, may lead to severe and permanent disability involving this important weight bearing joint. By emphasizing the possibility of hip disease in every case of pain in and about the knee where knee disease is not found, it is hoped that hip disease will be diagnosed earlier so that early treatment can be given and subsequent disability reduced.—Robert W. Florence, M.D., Tacoma, Wash.: *Northwest Med.*, 58:204, February, 1959.

Cancer Detection in the Small Hospital

HARRY A. DUNCAN, M.D., and KENNETH POLEN, M.T.

THERE is nothing in the world so unpopular as a truly new concept. When the first automobile was manufactured old horse and buggy carriages were used for the auto's body. In fact, even the whip holder was left on the carriage. Papanicolaou did not bring forth an entirely new concept in 1928 when he reported finding cancer cells in vaginal secretions. Cytology had been employed previously in the study of inflammatory exudates and secretions from pleural and peritoneal cavities.

That cancer cells might be found on the surface of an apparently normal organ of a person with neither symptoms nor physical signs of the disease was a new concept in diagnosis. This observation excited little interest in the medical world but, when 20 years later he was found pursuing his study of cytology, the first reaction was to point out its impracticability. Doctors were already too busy with sick people, and it would cost at least \$25,000.00 to discover one case of cancer in the so-called healthy individual!

Our only object in submitting this paper is to show just how practical, how inexpensive and how lifesaving the cytology test can be even in a small county hospital of 50 beds not yet able to support a pathologist.

A cancer detection clinic was started in the Holmes County Joel Pomerene Memorial Hospital, Millersburg, Ohio, in January, 1946. From 1948 to 1950 the cytology test was employed on any accessible lesion of skin or mucous membrane as well as all uterine cervixes. The results were most promising, and, with the support of the local cancer society, it was decided to expand the program to reach every woman in Holmes County, if possible.

First, a technician was trained at McGill University, Montreal, in the technique of staining and screening of cytologic smears. Second, cytology kits were supplied to the physicians of the county. Doctor-patient relationship was strictly maintained. The result of the smear test was mailed to the family doctor with the request that he do a biopsy if the test was positive, or send more smears if suspicious.

All smears were taken with a wooden scraper and fixed in ether-alcohol or stained by the Hematoxylin OG 6 and EA Method. We deemed it important that they be taken from the squamous margin of the squamocolumnar junction. Smears were brought to the hospital laboratory, where

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they were stained and studied. After screening by the cytologist all positive and suspicious smears were confirmed by a physician cytologist before being reported to the family doctor. The cytology test is only a screening test and not a final diagnosis. Records were kept of all cases. Biopsied tissue was sent to the pathology laboratory of either Ohio State University or Western Reserve University.

Eighty per cent of those seeking the service of our cancer detection clinic were women. For that reason it seemed wise to limit our report to cancer of the uterus where the smear test is very important as a means of early diagnosis. We have chosen the eight years from 1950-1957. The material presented covers the smears both from the clinic and from the doctors' offices.

The growth of the program can be seen in the following report of the number of patients examined and the findings:

Year	New Patients	Repeat	Ca Cervix	Ca Fundus
1950	242	102	2	0
1951	151	130	3	0
1952	128	117	0	0
1953	139	127	1	1
1954	128	142	2	0
1955	144	161	2	0
1956	678	110	7	0
1957	934	142	11	1
	2544	1031	28	2

Summary of Patients With Positive Results

Age	Cancer Unsuspected	Cancer Suspected
21 - 30	6	0
31 - 40	10	0
41 - 50	4	1
51 - 60	2	3
61 - 76	2	2
	24	6

Thirty patients were cytologically positive and proven by biopsy. Six of these were suspected.

Four of the six were suspected because of spotting after intercourse though there were no physical signs and two patients had vaginal bleeding plus stony hard cervixes and evidence of metastasis in the pelvis. Both patients died within ten months.

Of two adenocarcinomas of fundus found, one was suspected. Three patients with carcinomas of cervix had vaginal spotting but no physical signs of cancer. Two patients exhibited far advanced carcinomas of cervix with physical signs. Ten patients had invasive carcinomas of cervix, and seven pre-invasive, while eleven were found to be carcinoma-in-situ.

Summary of Patients With False Positive Results (Group III B)

Three patients were placed in this group because of positive Papanicolaou smears but negative biopsies. Their ages were 27, 31 and 84 years. Such patients should be rechecked by smear every six months.

In one case where our Papanicolaou test was positive but the biopsy negative we repeated the smear three times over a period of two years and the result was positive each time. This case we regard as in Group III C. We then requested that the cervix be amputated and serially sectioned. This time the pathology report came back "multiple areas of carcinoma-in-situ and one small focus of undifferentiated squamous cell carcinoma filling one cervical cyst. The tumor has not yet invaded the underlying tissue." This report regarding a 35 year old woman was dated November 24, 1952. Today she is one of the most active and useful women of her community.

Summary of Patients With Suspicious Results (Groups II and III)

Age	Cytology*	Biopsy
15	II B	Dysplasia
20	II B	Dysplasia
30	II B	Dysplasia
28	III A	Dysplasia
33	III B	Metaplasia
36	III A	Leukoplakia
49	III A	Hyperplasia
57	III A	Cervicitis
69	III A	Cervicitis

Interpretation of Cytology by Dr. J. E. Ayre, Montreal:

No cancer cells found.

Group I. Suspicious cells. Atypical morphology. Appears benign, but should: (A) Recheck in 3 months; (B) Biopsy. Group II. Atypical cells of cancer-potential type (pre-cancer cell complex): (A) Indicative of hyperactive growth; (B) Follow carefully; Recheck. Group III. Positive for cells of cancer type. (A, B, or C, indicates degree of Cytologic certainty; for example, C, indicates absolute evidence of malignancy. It does not refer to the stage of the cancer.)

All suspicious smears call for repeated examinations at intervals of 6 to 12 months depending on the degree of suspicion.

The lost positive or suspicious patients are those

who do not return for reexamination because of misunderstanding, because of moving to another home, or because further examination or treatment are sought in another community.

Summary of Patients Lost to Study (Suspicious Results, Not Reexamined)

Age	Cytology*
39	III A
37	II B
46	II B
54	III B

As of this date we have not learned of any false negatives in our laboratory.

Our suggestion that women should have a repeat examination at least once yearly was followed by a fair number of the patients. During this eight year period 1031 availed themselves of this opportunity. However, in the 1031 examinations only two patients with symptomless cancer were found, and they were discovered six years after their first examination. With these two exceptions, all of our positive and suspicious cases were found on the first examination.

On the basis of a negative smear one might be tempted to set the date for a second test more distant than one year but should be careful not to convey a sense of false security. On the other hand since six of our biopsy proven positives were found in the 20 to 30 year age group and 10 in the 30 to 40 year age group we would emphasize the importance of the test in these younger women.

The greatest value of the cytologic smear is in young women with grossly normal uteri. The obstetrician has a wonderful opportunity to perform this test at his first examination of his pregnant patient. Smears taken during pregnancy and those taken postpartum are in no way difficult to interpret. In young women the smear test has proven of value in revealing not only cancer and precancerous lesions but inflammatory and parasitic diseases that present no clinical symptoms.

The results of the Holmes County Uterine Cancer Detection program have been gratifying. Our local physicians and our people are interested. Our local cancer society finances the program. It costs the patients nothing and the doctors feel free to send the smears to the laboratory.

This effort does not promise to reduce the incidence of uterine cancer but it will reduce morbidity and promises to reduce mortality in uterine cancer to a point where death from this cause should be rare.

*Classification of cytology is that of Dr. J. E. Ayre, McGill University, Montreal, Canada.

Anorexia Nervosa

DANIEL T. WEIDENTHAL, M.D.

IN the late nineteenth century, Sir William Gull described a cachectic state which had a psychological basis and occurred in females. He termed this illness anorexia nervosa.⁶ At different times it has been thought to be a psychosis allied to schizophrenia, a form of manic depressive psychosis, and a severe psychoneurosis. The clinical picture of anorexia nervosa and some current concepts of management will be discussed.

All degrees of severity of the disease exist, from the mild case, the chronically thin individual who may never require hospitalization, to the patient in a profound degree of emaciation.² The history will reveal a gradual decrease in food intake. Typically, solid foods such as meat and fruit are omitted early, and lettuce may be the mainstay of the diet in the advanced disease. The patient may complain of a sensation of fullness in the stomach resulting in vomiting, or she may express the idea that food sticks in the throat to make swallowing difficult.

There is a striking disparity between appearance and level of activity. It is not uncommon for a severely malnourished victim to busy herself restlessly around the ward. The recognition of this characteristic incongruity of physical hyperactivity and severe emaciation is most important in making this diagnosis. Vigorous denial of the illness is also part of the picture of anorexia nervosa. Hospitalization is usually instituted at the request of anxious parents and relatives, for seldom is the patient herself sufficiently concerned about the dangerous degree of undernutrition. One author has designated anorexia, marked weight loss, and amenorrhea as the *sine qua non* of the disease.¹ Pallor, constipation, hypotension, hypoglycemia, low basal metabolic rate, and decreased 17-ketosteroid levels are also frequent findings.¹ The victims are young women, usually with a history of previous neurotic difficulties. The appetite loss is not a passive anorexia, but an active, morbid aversion to food and eating.

Differential Diagnosis

Confusion arises in differentiating this condition from postpubertal panhypopituitarism (Simmonds' disease) which it resembles. Most commonly this is caused by a chromophobe adenoma pressing on surrounding pituitary tissue. Craniopharyngioma and postpartum pituitary necrosis due to embolism may also result in panhypopitui-

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tarism. There is a secondary atrophy of the thyroid, adrenals, and gonads and a clinical picture of lethargy, disorientation, decreased libido, amenorrhea, and intolerance to cold. Cachexia may also be evident, resulting in a picture similar to classical anorexia nervosa.⁸

It should be noted that anorexia nervosa is most common in young nulliparous females, while pituitary insufficiency is rare in this group. The incongruous alertness of the anorexia patient, as mentioned previously, may also help in differentiation. The response of the 17-ketosteroids to ACTH is elevated in pituitary insufficiency and normal in anorexia nervosa. The psychiatric history is important, for frequently anorexia nervosa will begin with a precipitating event, commonly involving the loss of a loved one. In one series fear of obesity with voluntary weight reduction was the initiating event.⁷

Additional help in differential diagnosis can be obtained if food is withheld for 24 hours. The patient with pituitary insufficiency may be ravenously hungry in contrast to the anorexic patient, who may show no increase in appetite. Review of the diet can also furnish valuable information. The patient described in this paper gave a history of a general inability to eat because of "phlegm" in her throat, but could consume special brands of breakfast food, tea, and coffee without difficulty. She volunteered that the other brands made her choke. It would be unusual for an organic lesion to cause this type of selectivity in food intake.

Case Report

The patient, a 20 year old white nulliparous woman, was an only child. As a child, she was a toilet training problem. She slept in the same room with the parents until age five. She developed a very close relationship with the father, and there was at least one episode of sleeping in the same bed with him, though the patient denied sex play. Both parents are now chronic alcoholics. She recalls early episodes when her father vomited at the dinner table and since the age of six, she has taken her food to another room to eat alone. The patient has shown marked phobic reactions in the past describing fear of riding in an elevator and of traveling on a bus by herself.

In August of 1953 at the age of 16 she developed

anorexia. She left school earlier that year allegedly because of poor scholastic performance. Soon after, she claims that she was sexually attacked on two occasions by men, but she denies being raped. The anorexia began about this time as a refusal to drink warm milk and gradually increased to include refusal of solid foods. Specific brand items, e.g. Kix breakfast food and Lipton's tea were tolerated however. Much enjoyment was derived from preparing foods for other members of the family during this period, but the patient would not indulge, insisting that the food induced choking. Menses, which started in 1950 at age 13, ceased in November of 1953 as her weight dropped from 104 to 79 pounds. Because of this weight loss she was admitted to University Hospitals, Cleveland, (first admission).

She exhibited hypertension and bradycardia, her skin was pale, and her breasts were poorly developed. Basal metabolic rate, fasting blood sugar, and urinary 17-ketosteroid excretion were decreased. Skull films, including views of the sella were normal. Her dietary intake in the hospital averaged only 150 calories per day.

The diagnosis of anorexia nervosa was made and psychiatric treatment was recommended. She was discharged to the psychiatric outpatient department but did not keep her appointments, apparently due to her parents' failure to bring her to this clinic. She did poorly, seemingly oblivious of her progressive wasting.

Three months after her first admission she was admitted again because of failure to gain weight. Her diet was increased to 2500 calories, but she failed to increase her weight. It was discovered that she was surreptitiously disposing of her food. Gastric tube feeding was begun and her weight rapidly increased. She did not seem resentful or disturbed by this procedure. Five units of insulin was given before each meal to stimulate her appetite. When the feedings were stopped, her weight started to fall. Areas of brown pigmentation were seen on her skin, which subsequently cleared. Some ankle edema was also noted. In spite of her pathetic figure she insisted that she was feeling fine and was well adjusted with a happy family and friends. Her physical activity was out of proportion to her degree of emaciation.

Active psychotherapy was begun. In the beginning she was very cooperative and almost euphoric. She had no delusional or paranoid thoughts. At first there was no deep probing of sexual or traumatic material, and she did well. At the suggestion of the house staff, the psychiatrist was given full charge of the patient and was "her doctor." Later her fears of womanhood and independence as well as the secondary gains of her disease, such as being fed and getting sympathy, were pointed out to her. Anger and resentment were then manifest, and she demonstrated fear of men and of sexuality. Her fear was accompanied by a sudden loss of insight and a decrease in weight. She then apparently provoked her father to remove her from the hospital.

Because he felt he had accentuated her fears and that the interviews were too traumatic, the therapist suggested that a female case worker take over the treatment. Since 1954 the patient has been seen two times a week by a psychiatric case worker. Her medical problems have been handled by an internist in communication with the worker.

In the following two years she improved psychologically, but her weight continued to fluctuate between 80 and 90 pounds. She had few colds and handled her illnesses well, recovering rapidly. As her weight dropped, she seemed brighter and more alert. For one three month period, contact with our hospital was broken, but she later returned happier and more feminine in her appearance. It was learned that she had been on vacation and separated from her father. Frequently she talked of getting a job but found it difficult to get along without her mother. In April of 1956, her case worker changed. Subsequently she missed many ap-

pointments with the new therapist. Early in 1957, she cut her food intake and again began losing weight. She appeared angry and depressed and, in April, she was readmitted to the hospital. Her weight had fallen from 90 to 75 pounds.

In the hospital she refused to eat and a gastric tube was again introduced. She received 3000 calories a day. During her weight gain, she developed some pitting edema. With strong support and encouragement she began to feed herself and gradually showed more interest in hospital activities. Testosterone was employed as an anabolic agent and the physician managing the case was impressed by the acceleration in weight gain and the increased physical activity occurring concomitant with its administration. Three months later she was discharged weighing 100 pounds.

She continues to be followed by the internist and a resident psychiatric physician, who note that since her discharge she has been able to come to the hospital for the first time without her mother. Her appearance and attitude have also improved. There has been another incident of sexual attack reported since her discharge. Her earlier described fears of riding on buses and elevators are considerably diminished.

Discussion

One school of thought holds that anorexia nervosa stems from a relationship with a mother who shows marked ambivalence about food giving. Outwardly she encourages her child to eat, but she does this in a begrudging manner which is sensed by her offspring. Unconsciously the mother wishes for the child's death and the child complies. Frequently there is a seductive father who intensifies the child's fears and the mother's hatred toward the child.

Most cases appear during adolescence when the jealousy of a neurotic mother increases.⁴ Because of the mother's strong wish for the child's death, she will not readily allow the child to get well. In this case, the parents have been a problem, repeatedly wishing to pull the child out of therapy and showing obvious displeasure with the child's steps toward emotional health. It was noted on the ward that the mother, if allowed to come during the patient's mealtime, would eat a great part of the patient's meal herself. It is interesting that the mother appeared emaciated and in many ways resembled the patient.

The psychic defense of denial, with the patient refusing to admit to herself the existence of her illness, is prominent in this disease. Most patients are not consciously disturbed by their physical appearance and frequently wear garments which expose their spindly arms and legs.⁵

Physicians caring for patients with anorexia nervosa must be constantly alert to avoid sharing the patient's denial so that physical treatment, which may be lifesaving, is not neglected. The patient with anorexia nervosa, whose body weight is markedly reduced, may suddenly show a rapid deterioration which can end fatally despite energetic, but too long delayed, tube feeding.

Kay and Leigh studied a series of 38 patients

and found the sex incidence 34 women to 4 men. Most American authors do not recognize this diagnosis in males. In two thirds of the group, environmental factors appear to have precipitated the illness; e. g. death of a loved one, broken engagement, or physical illness. One patient had been sexually assaulted, though close to half of the total group related the onset of their illness to voluntary dieting. Previous neurotic symptoms, e. g. depression, headaches, and phobias were also present in half the group.

From studying the families of their patients, it was found that:

(1) Psychosis in the family is rare; (2) gross disturbances in social or economic circumstances occur in a small minority; (3) invalidism, hypochondriasis or pre-occupation with diet was found in half the families; (4) parental neurosis is as common in these families as among the parents of other neurotic groups.⁷ Stable parents and good parent-child relationships are rare.

Current Therapy

The management of anorexia nervosa can be divided into two parts.

The first objective consists of eliminating the immediate danger of death from inanition. This can be accomplished by vigorous medical management with the use of tube feeding and adjuvants such as insulin and testosterone where indicated. Weight may be kept at reasonable levels so that efforts may be turned toward the long range problem of rehabilitation.

The second objective is the establishment of a satisfactory personality adjustment. It is generally accepted that successful management of this disease depends on the patient's building a strong relationship with one person.⁵ The patient is permitted to lean on the doctor but further regression is discouraged. Normal activity and sociability are fostered whenever possible. If not amenable to outpatient therapy, the individual may have to be hospitalized and allowed to regress further. The patient will be reassured by the doctor's confidence in her ability to overcome the disease, and pictures before and after treatment of previous patients may be helpful.

Two questions related to increasing the caloric intake of patients with anorexia nervosa are worthy of further investigation. The first concerns the observation that emaciated patients fail to gain weight at the expected rate when on high caloric diets. In most instances it will be found that the patient is surreptitiously disposing of food in ingenious ways that may include induced vomiting. However, it is possible that some secondary absorption defect occurs in this disease.

The patient described in this report was being tube-fed a liquid diet of 2000 to 3000 calories in multiple small feedings and no evidence of vomiting was detected with careful observation. Over a five week period of such a regimen she gained only six and a half pounds. Every ten days for the next five weeks 1.5 cc. of testosterone cyclopropionate was given and her weight increased by 15 pounds.

The second question that then arises concerns the role of this sex steroid therapy. Is it of real value in this disease? Further studies with a large group of patients would be useful.

Criteria of Cure

The criteria of cure in anorexia nervosa have not been universally established, which may account for the reported cure rates ranging from 100 per cent to 20 per cent.¹ It is clear that methods of therapy cannot be compared unless a standardized yardstick of therapeutic success is established. Some authors have employed the maintenance of adequate weight in evaluating therapy while the state of the total personality adjustment has been of most interest to others. It is widely held that anorexia nervosa has a psychological basis.⁶ Because of this, it seems necessary to take into account the psychological condition of the patient in evaluating the effectiveness of therapy. Bond has emphasized this aspect insisting that "cure" require that the patient achieve an acceptance of her femininity as well as the return of normal menstrual periods and adequate weight levels.

Another factor making evaluation of therapy difficult is the wide range of severity of the disease.² Severely emaciated hospitalized patients cannot be compared with the milder cases treated on an outpatient basis.

Summary

The clinical picture of anorexia nervosa is described with an illustrative case report. Where difficulty was encountered in making the diagnosis, the following points were found to be helpful:

1. Frequently a history of voluntary dieting can be elicited, with the patient unable to regain her appetite and control her downhill course.
2. Specific brands of food may be tolerated. One may observe choking or vomiting with the ingestion of other than the specified foods.
3. Vigorous activity may be seen in the face of extreme emaciation, with the patient denying the seriousness of her condition. It is felt that patients may actually exhibit their spindly appendages to the alarm of onlookers.

In a study of the families of patients it was

found that stable parents and good parent-child relationships were rare while invalidism, hypochondriasis and preoccupation with diet was a common finding.

Current therapy can be divided into two parts:

1. The maintenance of adequate weight to prevent death from inanition, by tube feeding if indicated.
2. Attempts at personality adjustment by superficial supportive therapy or psychoanalysis.

The wide range of cure rate is thought to be due to the great variation in the severity of the disease and to the variation in the definition of a "cure" rather than to the type of therapy employed.

Acknowledgment: I am indebted to Dr. Douglas Bond and Dr. George Bidder for their helpful criticism of this manuscript.

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Sight Lost in Glaucoma Cannot Be Restored

With our aging population, it will help the fight against blindness if the internist, the family physician, and the industrial physician keep in mind the frequency of such sight-destroying diseases as glaucoma. The only hope today of reducing its effect as a common cause of blindness is through early detection, because the best one can do now is to arrest its further progress after it has been diagnosed: Lost sight cannot be restored.

In rural towns and villages where patients may see an oculist only rarely, the general practitioner would serve his patients well if he would learn the technic of tonometry. And it behooves all physicians to have a high threshold of suspicion for glaucoma and to urge individuals with suspicious signs to obtain a thorough ophthalmologic examination.—Franklin M. Foote, M.D., New York City: *New York State J. Med.*, 59-5:811, March 1, 1959.

Pelvic Cancer

The incidence of pelvic cancer can be materially reduced by physicians stressing the importance of annual physical examinations and by the establishment of state and county committees for the study of pelvic cancer.—Charles E. Flowers, Jr., M.D., et al.: *Southern M. J.*, 51:1497, December, 1958.

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEFFEL, M. D.
Columbus, Ohio, Chairman

Following is the summary of a case which was discussed before the Franklin County Pelvic Cancer Delay Committee on February 18, at its regular monthly meeting held at the University Health Center.

Case No. 68. The patient is a 48 year old white woman with a history of vaginal bleeding for 10 months. She saw a physician 10 months ago and he prescribed oral medication for the bleeding. No pelvic examination was done at that time.

The patient was seen by another physician one week ago. She was hospitalized immediately. Pelvic examination reveals firm induration of the cervix by a cauliflower growth. This extended halfway to the pelvic wall, both sides. Excision of local lesion reported as squamous cell carcinoma of the cervix.

Comments

DR. EZELL: At age 48 vaginal bleeding other than absolute normal menstrual type is a red signal flag of danger.

DR. POMEROY: This patient has had a 10 month loss of time since the onset of symptoms that is directly referable to physician delay.

DR. HOLZAEFFEL: Patient has a clinical stage II squamous cell carcinoma of the cervix. Possible cure rate for her is in the range of 55 per cent. This rate could well have been 90 per cent by earlier institution of therapy. Patient delay is zero.

Persisting Proteinuria Is Consistent Sign of Renal Disease

Observations on 250 patients with orthostatic-type proteinuria (albuminuria) after interval periods averaging six years discredit the common belief that this condition represents a specific benign disorder of youth which disappears in later life and is without clinical significance.

Albuminuria (proteinuria) persisted in approximately 90 per cent of patients studied and progressed from the orthostatic to the constant (continuous) proteinuria pattern in over 30 per cent. This is considered evidence of corresponding increase in the underlying disease processes. In about one third of patients with simple orthostatic albuminuria, laboratory and clinical evidences of a variety of renal diseases were found on follow-up.

These observations clearly indicate that latency does not guarantee regression. On the contrary, it appears that over a long period of time these common miscellaneous latent renal disorders may constitute an important source of chronic renal disease in later life.—S. Edward King, M.D., New York City: *New York State J. Med.*, 59-5: 825, March 1, 1959.

Polycystic Disease of the Liver

PAUL E. GEIGER, M. D.

POLYCYSTIC disease of the liver is an uncommon congenital condition in which multiple thin-walled nonparasitic cysts containing clear fluid develop in the liver. Destruction of liver parenchyma results. The disease is frequently associated with polycystic disease of the kidneys. Associated polycystic disease of the lungs, pancreas, spleen and ovaries is less frequent.

Review of Literature

The etiology of this disease is a subject of considerable controversy. The most widely accepted theory is that it is a congenital anomaly of the bile ducts or their pretursors.¹ The resulting cysts are lined with cuboidal or flat epithelium and contain a clear watery fluid. There may be just a few cysts, or the liver may be almost replaced by them and fill the abdomen.

A history of other members of the family having the disease can be elicited in some cases. It is seen four times more often in women than in men.

Symptoms are seldom noted before the age of forty. The most common symptoms are pain in the liver area accompanied by an enlarging mass. Dyspepsia, dyspnea and jaundice are occasionally noted. With massive involvement of the entire liver, tests of liver function are almost uniformly normal. In a study of 24 cases Comfort et al.² noted that only 13 had presenting symptoms referable to the liver.

The diagnosis is usually made at surgery; in any event the correct diagnosis is seldom made prior to operation. Treatment for polycystic liver is usually not needed, but at the time of operation rupture of the larger cysts or marsupialization may be done. Removal of an entire left lobe for cystic disease of the liver has been recorded.¹

The association of polycystic disease of the liver with the same condition in the kidneys was first noted by Bristowe³ in 1856. Moschowitz⁴ reported on 85 cases of polycystic liver showing concomitant polycystic kidneys. His figures showed that in 19 per cent of cases of polycystic kidneys, polycystic disease of the liver is also found. Oppenheimer⁵ found polycystic liver in 28.5 per cent of people with polycystic kidneys.

Polycystic disease of the kidneys, although consistent with long life, is a greater threat to the life and health of the patient than is polycystic disease of the liver. This threat lies in its tendency to cause hypertension. Prognosis in poly-

The Author

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cystic disease of the liver thus usually depends on the degree of concomitant renal involvement. Elliot⁶ feels that hepatic insufficiency rarely develops in patients with polycystic disease of the liver. Niemetz et al.⁷ report two cases of progressive liver failure in polycystic liver disease resulting eventually in death.

Report of a Case

History. The patient, a 53 year old white housewife, was admitted to Riverside Hospital, Toledo, Ohio, with the chief complaint of continuous, sharp pain in the right lower chest aggravated by deep inspiration. It began four days previously. The following day she had nausea and vomiting of food recently ingested. She also complained of anorexia and insomnia.

The past history included tonsillectomy, a fractured right ankle, appendectomy, and hysterectomy. The latter two operations were performed for unknown reasons in 1947. The patient had no children. She had no urinary or lower digestive tract symptoms. She did not use alcoholic beverages or tobacco. Family history was inadequate. A physical examination done elsewhere one year previously revealed hepatomegaly.

Physical Examination. The patient was a thin woman who appeared chronically ill. She was alert, but slightly negativistic and obviously of low intelligence. Her blood pressure was 182/92, temperature 97.6°F., pulse rate 70/minute, respiratory rate 20/minute. Examination of her chest revealed dullness to percussion and diminished breath sounds over the right lung base. A friction rub was noted over the right lower chest anteriorly. No rales were heard. Examination of the abdomen revealed tenderness in the right hypochondrium with deep pressure with no rebound tenderness. A firm nontender epigastric mass was initially interpreted as liver. There was no tenderness over the kidneys. Rectal and pelvic examinations were not remarkable.

Laboratory Investigations

Urinalysis: Yellow, cloudy. Specific gravity 1.006 to 1.015 on three determinations. Albumin, trace to 1 plus on three determinations. No acetone or sugar. Red blood cells—8 to 20 on three determinations, with white blood cells 2 to 6 per high power field. Some yeast cells were seen. No casts.

Blood Count: Red blood cells 3.9 million; hematocrit 37; hemoglobin 12. White blood cell count normal with this differential: Lymphocytes 33 per cent; monocytes 6 per cent; eosinophils 9 per cent; neutrophils 49 per cent. Eosinophil count in per cent was 1.1. Slight anisocytosis and hypochromasia were noted.

The Kline test for syphilis was negative. Bilirubin-Direct: at 1 minute, 0.05; at 30 mins., .30; total was .60. Serum Protein: Total 6.2; albumin 4.0; globulin 2.2 Gm./100 cc. Thymol turbidity: 0.3 units. Bromsul-

phalein 1.5 per cent dye retention at 45 mins. Phenol-sulfonphthalein: at fifteen minutes 14.5 per cent; at two hours 16.5 per cent;—total 31 per cent excretion. Blood urea nitrogen: 26 mg./100 cc.

Stool Examination: No ova, cysts, parasites or blood.

Radiologic Studies

Chest on admission: "P-A radiograph of the chest shows no abnormality in soft tissues nor osseous thorax. There appears to be a bilateral basilar pleural reaction and/or effusion. There is some increased density in the right base which may represent irregular diaphragm. The patient has not taken a very deep inspiratory effort. Lung fields otherwise fairly clear. Heart normal in size. Mediastinum normal."

Upper Gastrointestinal Series: "Conclusion: Changes represent extrinsic pressure on stomach and small bowel as well as colon, probably by a large mass in the upper abdomen. There is no evidence of intrinsic lesion in the G.I. tract."

Cholecystogram: "Conclusion: Good functioning gallbladder. No radiopaque stones identified."

Hospital Course

During the patient's first several days in the hospital her highest temperature was 99.6° orally, but she was treated for pleurisy on the basis of pleuritic pain in the right base. She was given tetracycline.

It was felt that the patient had hepatomegaly with a mass either intrinsic or extrinsic to the liver extending to the umbilicus. Rather rapid subsidence of her pleuritic symptoms occurred after several days' hospitalization and the tetracycline was discontinued. No other cause, other than a high diaphragm on the right, secondary to probable liver enlargement, could be found to account for her pleurisy.

Surgical consultation was obtained on the tenth hospital day and abdominal laparotomy was recommended to determine the origin and extent of the abdominal mass.

Operation: On February 16, the twelfth hospital day, "exploratory laparotomy was performed through a left paramedian incision just opposite the umbilicus. There was a considerable amount of serous fluid present in the abdominal cavity. The liver was studded with multiple nodules scattered throughout both lobes. These nodules, where they were superficial, looked like blebs beneath the surface of the liver. On rupture, a clear fluid came out. Two biopsies of the liver were made. These biopsy wounds were closed with Gelfoam® and catgut sutures.

"On exploration no mass was found involving the bowel. The uterus apparently had been removed with both tubes and the right ovary. The left ovary was normal. The right kidney was markedly nodular and markedly enlarged, at least four times its usual size. This nodularity extended through both poles of the kidney. Whether or not it originated in the adrenal glands could not be ascertained. The left kidney was similarly nodular, but not more than two times its normal size, and the nodularity was most prominent in the superior pole of the left kidney. After taking our liver biopsies, the abdomen was closed."

Pathologic Report: "Microscopic examination of the biopsy specimens of the liver shows it to be composed of liver parenchyma covered on its surface by a rather thick fibrous capsule. The capsule is composed of rather densely arranged fibrous connective tissue, throughout which are scattered a number of small tubular structures lined by cuboidal epithelium. Some of these structures are dilated to form small cystic elements devoid of any content. The surrounding stroma shows a rather heavy focal infiltration of lymphocytes, plasma cells and an occasional neutrophilic leukocyte. The underlying parenchyma shows an arrangement of liver cells into rather small lobules separated from each other by strands of fibrous connective tissue. The individual liver cells are

uniform in size, shape and staining reaction and present a finely granular appearance. The supporting and surrounding fibrous tissue shows an infiltration of lymphocytes, plasma cells and the occasional neutrophilic leukocyte." The pathologic diagnosis is '*Micronodular cirrhosis of the liver. Subserosal cyst of the liver.*'"

Postoperative course: The patient's postoperative course was not remarkable. She recovered satisfactorily for discharge on the seventh postoperative day.

An intravenous pyelogram was made prior to discharge and was reported as follows: "Conclusion: Apparent function of both kidneys to some extent but with incomplete and irregular filling, insufficient to allow for any definitive interpretation. Not incompatible with polycystic disease of the kidneys. Ureters are not filled nor is the urinary bladder."

Follow-up: The patient is known to be able to carry on her activities as a housewife at the present time. She shows no obvious change in her condition at this writing which is one year from the time of her initial diagnosis.

Summary and Conclusions

We have reported the study of a 53 year old woman exhibiting polycystic disease of the liver associated with polycystic disease of the kidneys.

The diagnoses were confirmed by surgical exploration of the abdomen and by x-ray studies.

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Peripheral Arterial Occlusion Requires Exploration

Acute peripheral arterial occlusions are surgical emergencies which require exploration. In all except the aorta the surgery can be performed in about 30 minutes under local anesthesia. The procedure is well tolerated and the immediate relief obtained is dramatic. This type of surgery is much better tolerated than the continued severe pain of nonsurgical therapy.—Eugene T. Hansbrough, M. D., Poplar Bluff, Mo.: *Missouri Med.*, 56:270, March, 1959.

Treatment for Nodular Goiter With Hyperthyroidism

Thyroidectomy remains the best treatment for nodular goiter with hyperthyroidism. I¹³¹ in large doses controls the hyperthyroidism associated with small nodular goiters but rarely gives satisfactory control of hyperthyroidism associated with large nodular goiters and does not significantly reduce the size of the goiter.—George Crile, Jr., M. D., Cleveland: *World-Wide Abstracts*, 2:11, Mar., 1959.

Dendritic Ulcer

A Case Report on Preventable Blindness

WILLIAM H. HAVENER, M. D.

A BLIND EYE is a serious loss to both patient and community. Awareness of the preventable nature of a significant portion of this blindness should help in reducing the incidence of such tragedies. The representative cases to be presented here are selected to emphasize relatively common causes of blindness which can in many instances be averted by proper, timely care.

Case Report

One year ago this 14 year old boy developed a foreign body sensation in his right eye, although there was no history of injury. Irritation and redness, with photophobia and tearing, continued to be quite annoying for a week, at which time medical advice was sought.

The eye was described as showing considerable redness, with a faint grey, irregular linear defect on the lower cornea. A combination of antibiotics and steroid was prescribed for hourly topical use, with the intent of "shotgunning" either bacterial or allergic disease. During the next three weeks the eye was more comfortable and less red, however the cornea gradually developed a faint grey discoloration in the region of the previous linear defect. This grey area eventually became quite dense and involved the central cornea.

A year after the initial attack, the eye was comfortable and not inflamed, but the corneal scar had reduced vision to the ability to count fingers at four feet.

Discussion

The herpes simplex ("cold sore") virus is the commonest virus infection of the cornea. A dendritic ulcer is absolutely pathognomonic of a herpetic etiology. Such an ulcer destroys the corneal epithelium in a linear branching fashion, which resembles a lightning flash or the branching pattern of a nerve dendrite. These ulcers stain a brilliant green color with fluorescein 1 per cent. A large dendritic ulcer is readily identified with the naked eye. Unfortunately the smaller ones appear as a patch of greyish corneal edema with a few central flecks of greenish staining.

The usual history is very similar to the case described, in that the physician encounters a relatively minor appearing corneal lesion, which has persisted stubbornly and causes considerable discomfort. There is a marked tendency to recurrence in the same eye, and the history of such a previous episode is of diagnostic help.

Steroid therapy during the dendritic phase of corneal herpes has often been reported to cause dense opacity of the corneal stroma. Definite experimental and clinical data prove that resistance to herpes simplex is markedly reduced by steroids. Most ophthalmologists agree, therefore, that steroid therapy of dendritic ulcers is contraindicated. Antibiotics do not affect this virus, but should be used to prevent secondary bacterial infection.

Iodine cauterization of the ulcer is the treatment of choice. During the dendritic phase, the virus particles are limited to the epithelium, re-

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moval of which will cure the infection. Under cocaine anesthesia (which is chosen because it damages corneal epithelium making it easier to remove; and because it precipitates iodine as an insoluble salt, minimizing deep penetration and damage) a tiny toothpick cotton swab just moist with 3 per cent iodine is used to remove every trace of infected epithelium. Usually this is done with the aid of magnification and good illumination, and at least a millimeter of epithelium is removed to each side of the dendritic figure. With care, this may be done without producing corneal scarring. Antibiotic ointment (such as Neosporin®) is instilled and a pressure dressing applied for 24 hours. This procedure usually causes severe discomfort for several hours, and prescription of codeine and pentobarbital is necessary.

Adequate cauterization usually results in complete healing within several days, whereas untreated herpetic keratitis often lasts for many weeks. The recurrent nature of herpetic keratitis has led to many attempts at preventive therapy. There is little evidence to prove that repeated vaccination or any of the other methods are helpful. Iodine cautery of cutaneous herpetic lesions on the lids would seem reasonable.

The relationship between dendritic ulcer and eye trauma is of considerable medicolegal importance. The foreign-body-like sensation caused by a dendritic ulcer leads the patient to assume trauma has occurred. Simple corneal injury, without virus infection, will not produce the clinical syndrome of a dendritic ulcer. Inoculation of virus-infected material upon a cornea will, of course, produce a typical infection, but it is unlikely that such contamination would occur. Trauma to a previously involved cornea does not seem to trigger a recurrence. In the great majority of cases there can be no question of industrial liability.



MATERNAL HEALTH IN OHIO

Case No. 138

This patient, a 21 year old, white, Para V, died in her sixth postpartum day. Her past history had been essentially uneventful and she had delivered four normal term children after normal pregnancies and labors. With a last menstrual period June 30, this current gestation was apparently uneventful until January (the 28th week), when the patient had a moderately heavy episode of painless vaginal bleeding which subsided spontaneously. She was found to have an albuminuria at about the 25th week; her prenatal care was inadequate, consisting of only several visits. We have no other evidence of edema, hypertension, etc.

She began to bleed again on February 26, when in her 34th week of gestation she was admitted to the hospital. On admission her bleeding was found to be scant and she pursued a desultory type of labor. She was seen by a consultant five hours after admission. He elected to allow her to continue in labor. Some 20 hours later the patient began to bleed profusely. A cesarean section was done under *ether* anesthesia, delivering a living baby February 27; weight was not recorded. She bled profusely and continued to do so postoperatively. Details of the surgery and findings were not reported. Seven pints of blood were administered by two "cut downs" before the patient showed signs of reacting from shock.

During the ensuing 24 hours her urinary output was only 100 cc. It was recognized that she had a relative anuria. Her blood urea nitrogen rose from 42 to 171. Day by day she became more lethargic and died in uremia on the sixth postoperative day. Details of progress and management during this time were not recorded. The patient became lethargic, went into coma and died on March 4. Autopsy permission was obtained.

Pathological Diagnosis: Aseptic necrosis of subinvolved postpartum uterus; intestinal hemorrhage, uremic type; degenerative tubular disease of the kidneys in a regenerative phase, which was consistent with the clinical picture of uremia; cutaneous purpura.

Comment

This case poses a number of questions which remain unanswered because of inadequate data. What was the fibrinogen level?

The Committee voted this a nonpreventable death. The dissenting minority raised the question, "Why was a vaginal examination and cesarean section not done earlier for this obvious placenta praevia?" Such a course would have obviated the necessity of the large quantity of blood, which undoubtedly precipitated the lower nephron syndrome. Committee members felt blood should have been available for the patient shortly after her admission, and further considered that in

TOPIC THIS MONTH:

Maternal Deaths* Involving Hemorrhage

view of the pathology of the uterus, at operation (?) a hysterectomy would have been feasible.

Case No. 158

This patient was a 35 year old white, Para IV, who died in shock three hours and 15 minutes following delivery. Her past history was negative; her previous pregnancies and deliveries were normal; and her prenatal care with the present gestation was said to be adequate, with four visits (?). Last menstrual period not recorded.

At term, the patient went into spontaneous labor on April 8. During the course of the labor, which lasted only six hours and 30 minutes, she had vaginal bleeding and complained of feeling faint. She was admitted to the hospital and prepared in the usual manner. Although bleeding was noted, it was not apparently profuse enough to alert the observers. Under ether anesthesia, administered by a nurse anesthetist, the patient spontaneously delivered a term stillborn infant. Delivery of the fetus was immediately followed by a prematurely separated placenta and a large gush of blood estimated to be 500 cubic centimeters.

The patient then became pale and cyanotic. Preparation was made for transfusion and she was given Gentran® and molar lactate intravenously. In spite of intravenous Pitocin®, intramuscular ergotrate, fundal massage, and vaginal packing, postpartum bleeding persisted. When the hemorrhage diminished slightly, the cervix was inspected and a laceration repaired. A blood transfusion was started two hours after delivery, but the patient progressed into deeper shock and expired three hours and 15 minutes postpartum, April 9. Autopsy permission was refused.

Cause of Death: Postpartum vasomotor collapse; abruptio placenta. (Cervical laceration and hemorrhage were not mentioned on the certificate.)

Comment

The Committee voted this a nonpreventable maternal death, by a narrow majority. However,

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by official representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

there was no indication that afibrinogenemia was considered; or that an extension of the cervical laceration into the parametrial tissue was ruled out. In addition, the failure to type and cross match the blood of this patient who was admitted bleeding, and the two hour lag in obtaining and starting blood transfusion created a controversy as to the preventability of this case.

Case No. 214

This patient was a 25 year old white, cesarean I, who died on her fourth postpartum (postoperative) day. She had had two laparotomies; the first for a ruptured appendix in 1949 and the second for adhesions in 1950. The last menstrual period was February 9.

The current gestation was complicated by scant bleeding at the 32nd week, and edema of the feet the month prior to her admission. Prenatal care considered adequate.

On October 21, at 3:00 a.m. in her 37th week, the patient experienced a sudden severe vaginal hemorrhage. She was admitted to the hospital at 3:30 a.m. not in active labor. The fetal heart was not audible. Pulse rate 96/min., blood pressure 120/60. A diagnosis of abruptio placenta was made and a low cervical cesarean section done, under spinal anesthesia. A stillborn male fetus was delivered and the placenta found to be almost completely separated. The patient showed evidence of shock during the procedure and was given two units of blood.

Postoperatively she apparently responded well, and took fluids by mouth. However, she developed a complete anuria, but laboratory studies were not reported. By evening, October 24, she developed convulsive seizures and it became apparent she had a renal "shut down" probably due to shock (?). Plans were formulated to transfer her to a facility where an artificial kidney was available, but before they could be implemented she died on October 25. An autopsy was done.

Pathological Diagnosis: Bilateral acute cortical necrosis of the kidneys; abruptio placenta.

Comment

This case was reviewed with interest by the Committee. Members felt that this was a case of hemorrhage in which the use of spinal anesthetic augmented arterial hypotension to the point where kidney damage ensued.

The Committee voted this a preventable maternal death. Records failed to note the use of Levophed®, which *may* have been used; members theorized that it might have contributed to renal damage by producing severe vascular constriction and ischemia.

Comment of Consultant

The following comment of a consultant, who is a specialist in Obstetrics and Gynecology, was given at the request of the Committee.

Before discussing these cases, I should like to postulate an operating criterion which I feel is basic in handling hemorrhage in third trimester or in labor: As long as *progress* is greater than *danger*, sit tight; when bleeding or hazard to mother or fetus exceeds progress, terminate the

pregnancy, by section if danger is immediate. The problem of delaying termination to secure added maturity of fetus in early third trimester is relative.

Case No. 138. If this is to be voted "preventable," it must be on a basis of the quoted "inadequate care." Once the patient was in the hospital, the care seems reasonable to the extent that her bleeding had subsided and she was in labor, although it was desultory, and the balance between progress toward the solution of her problem was greater than the immediate danger from bleeding. At this point, it seems reasonable that a vaginal examination might well have been done, under antiseptic conditions and with preparations complete for immediate section if the examination either disclosed a placenta praevia or instigated excessive bleeding. The failure to do these things, likewise contributes to "preventable" classification.

Subsequent care of the hemorrhage, shock, anuria and uremia may have been adequate but one or two units of fibrinogen also might have prevented the subsequent catastrophe. Certainly this case offers "less than ideal care."

Case No. 158. I cannot ignore the statement that *four* antepartum visits constitute "adequate care." This case may not have been altered by more visits, but any way that they are spaced, four visits in 40 weeks is inadequate. I can understand the failure to cross-match during the hospital portion of a six-hour labor if the bleeding were hidden, even though the patient "felt faint," if her blood pressure was adequate. The two-hour delay in securing blood may have been unavoidable, but if *not*, it constitutes a serious lapse in care.

The apparent diagnosis of abruptio and stillborn baby (how long dead?) is a perfect setup for afibrinogenemia. It should have been checked. I vote with the minority—less than ideal care.

Case No. 214. The bleeding is not mentioned as being excessive in the hospital and the patient's blood pressure was adequate. Furthermore, the inability to hear fetal heart tones does not always mean that they are not there, especially in obese patients.

In a 37 week gestation, I believe I would have accepted a spinal from a competent anesthetist in the hope of an unexpected salvage. Especially is this true if one must anticipate the holy indignation of a group of pediatricians in Peri-Natal study if the infant *had* been living, but died "of too much narcosis" (general anesthetic). The patient apparently received the blood during surgery, adequate to give good response postoperatively—no delay. I should like to have proof that this was *not* a blood incompatibility. If *not*, this death seems unavoidable to me.

A Clinicopathological Conference

Edited Under the Auspices of the Ohio Society of Pathologists

CHARLES BLUMSTEIN, M.D., *President*

Presentation of Case

THIS 74 year old white woman was first admitted to the University Hospital, Columbus, Ohio, three months prior to her death with the complaints of a mass in the right upper quadrant, general malaise, anorexia and fatigue. Six months prior to admission she suddenly developed anorexia and general malaise and for about one week thereafter she had mild fever and light-colored stools. The patient was seen by her local physician and improved without special medication. However, four and a half months later she noticed a large, tender mass in the right upper quadrant and marked anorexia. In the two weeks prior to admission the mass had enlarged and caused much discomfort.

In the previous six months she had lost 25 pounds. Twenty-seven years ago she began having frequent episodes of severe epigastric pain accompanied by nausea and vomiting, which would be relieved by morphine. These attacks continued for nine years. For the last four years she had been taking one tablet of digitalis every two days for "an arrhythmia."

On physical examination her blood pressure was 160/80, pulse rate 100/minute, respiratory rate 24 per minute, temperature 99°F. The patient was a slightly obese white woman, who appeared chronically ill but in no acute distress. Her lungs were clear to percussion and auscultation. Her heart rhythm was normal. A grade 3, high-pitched, blowing systolic murmur was heard best at the apex and transmitted all over the precordium. Her liver was palpable 10 to 12 cm. below the right costal margin. Its anterior aspect was stony hard and tender.

On admission, urinalysis was within normal limits. She had 16,800 white blood cells/cu. mm. with 16 per cent nonsegmented and 65 per cent segmented neutrophils, 19 per cent lymphocytes; her hemoglobin was 13.6 Gm. and hematocrit 42 per cent. The serologic test for syphilis was negative. Fasting blood sugar, prothrombin time, total protein and albumin/globulin ratio, inorganic phosphorus, cephalin flocculation, bromsulphalein, cholesterol and cholesterol esters were within normal limits. The alkaline phosphatase was 22.4 units. Later her white blood count rose to 33,000/cu. mm.

Presented by

- Robert M. Zollinger, M.D., Columbus, and
- Harry L. Reinhart, M.D., Columbus.

Edited by Emmerich von Haam, M.D., Columbus.

with 17 per cent nonsegmented and 70 per cent segmented neutrophils.

Chest x-rays demonstrated calcification in the walls of the aortic arch, and of the splenic and iliac arteries. Intravenous pyelogram revealed no abnormalities. Barium enema demonstrated no constrictive lesion in the colon. Oral cholecystogram failed to visualize the gallbladder and showed no evidence of stones.

The patient was treated symptomatically. On her eleventh hospital day a liver biopsy was performed. On the following day her total white blood count was 34,000/cu. mm., and she developed an allergic reaction shortly after penicillin was given. Her temperature rose to 102°. Four days later she was afebrile and her general condition continued improving until her discharge on the twentieth hospital day.

Second Admission

The patient was readmitted seven weeks later because of jaundice and progressive debility. Three weeks prior to admission she began to get progressively icteric and also had moderate difficulty in swallowing. Since her discharge she had remained bedfast at home due to marked weakness.

The patient appeared chronically ill, debilitated, hyperpneic and deeply jaundiced. Auscultation of her chest revealed decreased breath sounds over the right base and a few scattered crackling rales over both bases. Her heart had a regular, rapid rate of 108/minute. The liver was markedly enlarged and a 4 by 4 cm. nodule was felt below the liver edge.

Her white blood count was 34,800/cu. mm. with 47 per cent nonsegmented and 40 per cent segmented neutrophils; hemoglobin was 11.6 Gm., and hematocrit 33.5 per cent. The blood urea nitrogen was 44 mg/100 cc., the alkaline phosphatase

elevated to 29 units, the direct van den Bergh 6 and the total 8 mg./100 cc.

Digitalis therapy was continued. Because of her febrile course tetracycline was given and later changed to streptomycin and finally to Chloromycetin.[®] On her sixth hospital day auscultation of her lungs revealed coarse rales over the left posterior base, and a chest x-ray film demonstrated parenchymal infiltration in the left lower lobe. The patient required daily intravenous feedings. On the thirteenth hospital day she developed a temperature of 104 to 105 degrees and her white blood count rose to 36,500/cu. mm. with 94 per cent granulocytes. The patient continued to progress downhill and died on the twentieth hospital day.

Clinical Discussion

DR. ZOLLINGER: This is the case of a 74 year old woman who came to the hospital complaining of a mass in her right upper quadrant, general malaise, anorexia and fatigue. Whether or not this mass might be inflammatory or whether it is tumor comes to our mind. Six months ago she was seen for the same complaints by a local physician, who was obviously an internist, because he gave her water and with bedrest she improved. On surgery we call this the "dog" treatment—let the patients alone, they crawl under the bed and stay by themselves and in general tend to improve.

I want to call your attention in this history of the failure to give the patient's verbatim complaints. I am perfectly sure that this woman did not complain of a "right upper quadrant mass," of "malaise," or of "anorexia." I think that is typical of the histories we take around here. We listen to the patients a little and then put down what we think they mean by the words they use.

Differential Diagnosis of Lumps

What will give you a lump in the right upper quadrant? Certainly there is nothing in the abdominal wall to do it. I have seen very few gallbladders reach such size as to make a mass in the right upper quadrant, but some gallbladders have been described as of such size that they have been mistakenly operated upon as an ovarian cyst. We are not able to palpate the gallbladder as a rule.

How about acute cholecystitis? She might have it, or she might have had a perforation and omentum around it. But I have seen very few masses due to acute cholecystitis that last month after month and get bigger and bigger. We know too that in acute cholecystitis, as the size of the gallbladder increases, the mass itself tends to migrate more and more into the outer flank, so that in operating for acute cholecystitis we usually

try to make a subcostal incision, because the swollen, inflamed gallbladder presents itself more into the flank or right lumbar gutter and will not come straight up through the abdominal wall.

Nonspecific Symptoms

During this time she had lost 25 pounds. I think weight loss like unexplained fever usually means malignancy, and I assume that was the diagnosis most of us would make. However, weight loss in jaundiced patients has little diagnostic significance. The patient with hepatitis loses weight because he doesn't feel like eating and the smell of food is revolting. If he has gallstones or stones in the common duct, he will not eat because he does not want to precipitate an attack, and invariably his doctor has told him to stay off all fatty and fried foods, and people tend to lose weight on that restriction of diet alone. Finally you come to cancer, and those patients for some reason just plain lose weight. So weight loss in itself, at least to me, does not mean too much one way or the other, especially when it is associated with biliary tract disease with jaundice.

Bile Duct Pain

About 27 years ago she had frequent episodes of severe epigastric pain. That would make her about 47, which is a good time for gallstones. Severe epigastric pain accompanied by nausea and vomiting is a symptom which we have always believed as due to stone in the common duct or cystic duct. A few years ago we used to blow up the gallbladder with an inserted balloon and the patient had a feeling of gas, moderate indigestion, and a little shortness of breath. But if you put the distending balloon in the common duct, the patient had severe epigastric pain and invariably nausea and vomiting with splinting of the diaphragm. The pain impulses go through the splanchnic nerves to the major splanchnics, which in turn communicate with the lower sixth intercostal nerves which enervate the margins of the diaphragm, and any severe pain impulses coming from the biliary tract will give you shortness of breath.

What is Conservative?

She had not had an attack for about 15 years. That is the problem which surgeons always face in recommending biliary tract surgery to patients. They ask, "Is it necessary to have these gallstones out?" If the patient has not had a severe attack of colic for some time, it is pretty hard to say, "Yes, you must get them out," because they are liable to go along as this patient did for 15 years or longer and have no attack. On the other hand, if you have gallstones they will sooner or

later get you into trouble, and then we are going to have to remove the gallbladders in people of much older age groups, representing poor risks and more complications.

We can hardly justify the "poor risk" because we take pride around here in saying, "It makes no difference how old they are, the mortality is about the same." The morbidity, however, is not, and we have more difficulty from mobility, as you know. Our patient must have had a gallstone in her common duct and it would have been the conservative thing at that time to have recommended surgery and the risky thing to have told her not to have it. Now she is faced with a more serious problem probably related to her gallstones.

We would consider this woman a pretty good surgical risk at this time. They found a slightly elevated pulse and blood pressure and a grade 3 high-pitched blowing murmur, but all this means nothing to me whatever. I must say that if a patient with clear-cut indications of biliary tract disease walks around, has a good vital capacity and does not need oxygen, has a heart which has been working for 74 years, I suspect that it will keep on doing so also during a cholecystectomy. Of course she has been taking foxglove—every two days for the last four years. Her liver was down a little bit below the right costal margin and maybe she has a little heart failure which makes it that big and maybe she needs some more foxglove.

Cancer Is Tender, Cancer Is Hard

The next statement is that she had a stony hard mass. It might be a gallstone working its way out, but this I seriously doubt. It is tender, and we have all known for a long time that metastatic nodules to the liver are tender. There is something about malignancy which produces tenderness, and patients with metastatic nodules up against the parietes in front do suffer a fair amount of discomfort. Cerebrospinal nerves richly supply the peritoneum and the peritoneum, although not quite as sensitive as the tip of your finger, is still very sensitive. She has a stony hard, tender edge to her liver, and with this past history of hers I would say that she had had gallstones for years and that now she probably has a carcinoma of the gallbladder or the liver, which is just too bad.

Carcinoma is commonly associated with gallstones, but by the time you have reached the carcinoma age practically everybody has gallstones anyway. I have never used cancer as a valid argument in our sales talk to sell cholecystec-

tomy. If she had gallstones, she should have had them removed; now she has malignancy as the result.

Laboratory Tests—

She had a lot of laboratory tests. In the last year we spent \$220,000 in liver tests alone, which seems rather expensive. I was trying to think how long it had been since I paid any attention to shifts and segmented and nonsegmented neutrophils. It has been a mighty long time and it is going to be a much longer time before I do again. She had a hemoglobin of 13 grams and a hematocrit of 42. She was dehydrated and her hemoglobin probably should have been 20 if she had not lost that amount of weight. From blood volume determinations with radioactive compounds we know that anybody that is sick always requires at least 3 pints of blood. I know of very few things that will not elevate the BSP, and it is not supposed to be too good in the presence of jaundice. I have the impression that the test is not worth very much, but by the same token I am sure that it is a sort of tradition and no matter how jaundiced the patients are they still use it.

The only test that I regard as helpful in our case is the elevated alkaline phosphatase. That is supposed always to be elevated in the presence of metastatic malignancy or malignancy to the liver. Is her white count of 33,000 consistent with acute cholecystitis? We say that surgery is indicated if the count is 20,000 or above. Here it also could mean necrotic tumor. Any time you get malignancy associated with the gastrointestinal tract anywhere, you can get an elevated white count and an elevated temperature.

—X-Rays—

She had a lot of x-rays and her aortic arch was hard as cement. The intravenous pyelogram revealed no anomalies. It seems that nowadays everybody is getting his kidneys x-rayed. How much information do we gain from them? One of these days we are going to have to take a history and a physical and, so help us God, make a diagnosis on that basis and not build up a big hospital bill while we wait for these laboratory and x-ray examinations to come back. She had her colon examined for a lesion. I suppose we had to do that because of her big nodule in the liver.

There was no mention of change in bowel habits, but we know that it is impossible to make a diagnosis of carcinoma of the colon on the basis of history and physical examination unless it is big and obvious to anyone. Nothing was found. She had an oral cholecystogram, but as she was

not eating too well and was vomiting, I do not think that an oral cholecystogram would help much. If a patient has no appetite, does not feel like eating, you do not do much good by giving the dye by mouth.

—And Biopsy, Too

A liver biopsy was performed. I do not know whether this was a surgical biopsy or a needle biopsy. Needle biopsies are very simple procedures. The pathologist sometimes can't tell what he is looking at, but you get it anyway. The needle biopsy would have been worth while to our patient because she had a great big mass that you could put a needle into with less discomfort to the patient than an exploration. You should not do it on deeply jaundiced patients with signs of obstruction or if there is a bleeding tendency, and you should do it first thing in the morning so that you can observe the patient through the day should leakage of bile or blood take place as manifested by evidence of increased peritoneal irritation.

She was not operated upon, so I assume that this blind method was worth while, although she developed a fever of 102. They explained it by allergy to penicillin. The first penicillin reaction I ever saw was in France during the war. The patient's hands and feet were swollen and itchy and resembled lions' paws. From then on I have taken a very dim view of penicillin, and I am sure Dr. Saslaw would agree with me that these things should not be taken too lightly.

Antibiotics, of Course

On the second admission she was jaundiced and debilitated. When the patients are deeply jaundiced the question arises, "Should you attempt to relieve the obstruction surgically?" There is intense itching with obstructive jaundice, even your eyeballs burn, and this patient had difficulty in swallowing. Her liver was much enlarged and nodular. So I would think that must mean that she had a hepatoma or cholangioma or carcinoma of the gallbladder unless somebody missed a tumor coming from the body or tail of the pancreas.

Her laboratory work told us no more than that she was a seriously debilitated patient who came in during her last days. In this helpless position she was given, as you would expect, streptomycin, Chloromycetin and tetracycline. I looked up the cost of these and believe me her drug bill must have been very sizable. She went continuously downhill, but she went down fighting, full of streptomycin, Chloromycetin and tetracycline, with an obviously incurable situation from the beginning. She died from carcinoma of the gallbladder.

DR. REINHART: We have as our distinguished guest today Dr. Austin Weisberger from Western Reserve University, and I just wonder if he would have a few comments to make?

DR. WEISBERGER: Dr. Zollinger has really covered the ground very thoroughly and any remarks by me would be something like gilding the lily. Being a medical man, I share other people's partiality for the bromsulphalein test. In this particular case it actually does help because the question arises: Did the malignancy arise from the liver, or did it arise, as Dr. Zollinger has pointed out, somewhere else in the gastrointestinal tract? I think that with the results of the liver function tests, including the bromsulphalein, the chances that it would arise in the liver are rather slim, because almost invariably a hepatoma would develop in a patient who had cirrhosis.

I am sort of curious about how you feel about palpating nodules on the liver. I never can feel them and when people have felt them, often at autopsy they were not there, but everybody describes them and I suppose will keep on describing them. I would certainly agree that the gallbladder is a good spot for the cancer to have originated.

DR. ZOLLINGER: That was a good remark about the BSP because this test would tend to rule out cirrhosis.

Clinical Diagnosis

1. Carcinoma of gallbladder with invasion of liver.
2. Chronic cholecystitis and cholelithiasis.
3. Obstructive jaundice.

Pathological Diagnosis

1. Squamous cell carcinoma of gallbladder with invasion of and metastasis to liver.
2. Cholelithiasis.
3. Obstructive jaundice.

Pathological Discussion

DR. REINHART: Since Dr. Zollinger is interested in the economic aspects of the practice of medicine, I tabulated the cost of the patient's laboratory work. It came to \$97 on her first admission and to \$90 on the second admission, when her tests were practically a repetition of the previous ones. I think I would agree with Dr. Zollinger for the most part as to the diagnostic value of the \$187 invested in laboratory tests in this particular case.

The gross autopsy showed a cachectic, severely jaundiced patient with numerous decubital ulcers. The heart weighed 200 grams and showed moderate sclerosis of the coronary arteries. The spleen

was normal in size and was soft. The liver contained a large yellow mass 20 cm. in diameter in the gallbladder region, in the center of which was a small cavity containing three brown gallstones. The gallbladder could not be identified. The liver parenchyma contained several small nodules, apparently metastatic tumor. Examination of the pancreas and the entire gastrointestinal tract revealed no other neoplasm.

Microscopic Examination

Microscopic examination showed mild diffuse myocardial fibrosis, moderate bronchiectasis and generalized arteriosclerosis. Sections through the liver showed chronic cholangiolitis with bile stasis and a tumor composed of large anaplastic cells resembling those of a liver cell carcinoma. It has been said that the diagnosis of liver cell carcinoma can only be made at autopsy, which permits one to eliminate any other site of origin. This also means that one should be able to identify and isolate the gallbladder and eliminate it as a site of neoplasia.

The classical type of malignant hepatoma arises in association with cirrhosis of the liver, as has been pointed out by the clinical discussants. The classical type of carcinoma of the gallbladder arises in association with gallstones. Primary carcinoma of the liver occurs mostly in men of about this age, while the majority of carcinomas of the gallbladder occur in women. The distribution of the tumor with its main localization in the gallbladder region also makes an origin in the gallbladder more likely.

Tumors of the gallbladder may be of the adenocarcinoma or squamous cell carcinoma type. I feel we are dealing here with an anaplastic squamous cell carcinoma of the gallbladder developing in a chronically inflamed organ with gallstones and invading the liver in typical fashion.

Oral Cavity is Barometer Of Systemic Health

A more accurate term for inflammatory and/or degenerative changes in the gingiva and other periodontal structures is periodontal disease or periodontoclasia. Changes in the color, thickness, contour, consistency, surface texture, and position of the gingiva represent evidence of periodontal disease. Periodontal disease is generally the product of the interplay of a diseased systemic substrate and local irritating factors. Approximately 200 systemic diseases show changes in the gingiva and other periodontal tissues. The oral cavity is, therefore, an excellent barometer of systemic health.—E. Cheraskin, M. D., D.M.D., Birmingham, Ala.: *Clinical Med.*, 6:393, March, 1959.

Use of Analeptics as Adjuncts To Artificial Respiration

When respiratory failure occurs, the lifesaving step is to administer artificial respiration immediately. Respiratory stimulants should be used as adjuncts to the artificial respiration.

Respiratory stimulants are referred to as analeptics. They are of little benefit when respiratory failure is due to anoxia, excess of carbon dioxide, or a mechanical factor, such as increased intracranial pressure. They are unnecessary in the treatment of respiratory failure due to volatile anesthetics, such as ether, cyclopropane, etc., because the concentration in the blood can be reversed by artificial respiration. They may be of benefit if depression is due to the nonvolatile drugs, such as the barbiturates and similar hypnotics and the narcotics.

The recently introduced analeptic, known as Megimide,[®] appears to be superior to picrotoxin in the treatment of barbiturate overdosage. The patients are aroused sufficiently to give a history and discuss the dosage and which drug was taken. The antinarcotic drugs Nalline[®] and Lorphan[®] are suitable for the treatment of depression due to the opium alkaloids and the synthetic narcotics. They are ineffective for the treatment of barbiturate overdosage and overdosage to similar hypnotics.—John Adriani, M. D., and Margaret Kerr, M. D., New Orleans: *Southern M. J.*, 51:1532, Dec., 1958.

The Pre-Diabetic State in Man And Its Detection

The results of follow-up studies concerning the prediabetic state in man and its detection with the cortisone-glucose tolerance test are reported.

Their major objective has been to pinpoint the potential diabetic before the presence of diabetes is shown by present testing methods, so that they could study what processes exist to make this particular individual vulnerable to various factors which precipitate the clinical syndrome. Future developments, such as the possible acceptance of the cortisone-glucose tolerance as an indicator of abnormal carbohydrate tolerance, may result in the diagnosis of existing diabetes mellitus in a patient who would now be considered pre-diabetic. Perhaps the patient could be given help during the period which is now called latent.

Essentially all of the undiagnosed diabetics in this country could be detected in a few years if all of the close relatives of known diabetics were screened.—Abstracted from: Jerome W. Conn, M. D., Ann Arbor, Mich.: *Diabetes*, 7:347-357, September-October, 1958.

Medicare . . .

Instructions Issued on Statement with Reference to 2nd Trimester and Acute Emotional Disorders Complicating Maternity Cases of Dependents

THE Office of Dependents' Medical Care (Medicare) recently issued two directives in regard to treatment by physicians of authorized dependents of persons in the Armed Forces.

The first is entitled "Statement of Attending Physician with Reference to 2nd Trimester of Pregnancy on or before October 1, 1958."

The second relates to "Acute Emotional Disorders Complicating Maternity Care."

Reference to 2nd Trimester

1. A number of inquiries have been received from Medicare Contractors as to whether this office contemplates establishing a cut-off date for accepting the statement of the attending physician that the maternity patient, residing with sponsor, had reached the second trimester on or before October 1, 1958. (ODMC Letter No. 16-58, Par 5a(3))

2. The physician's statement is acceptable in those instances where the delivery is performed on or before April 30, 1959. This position was reached after careful consideration of the maximum normal period of gestation, a reasonable period of time to allow for unusual cases, and the information likely to be available to the physician when he made the determination that the patient had reached her second trimester of pregnancy on or before October 1, 1958.

3. Where delivery is performed after April 30, 1959, a PERMIT will be required when the dependent patient is residing with sponsor. There may be a few cases, certified to have reached the second trimester on or before October 1, 1958, which the physician believes to be so unusual as to warrant special consideration. In those instances where the physician requests that his claim be reconsidered, the fiscal administrator should forward, to this office, the DA Form 1863, the physician's statement, and any other pertinent information supporting the claim.

Acute Emotional Disorders Complicating Maternity Care

1. This letter supersedes any instructions previously issued concerning this subject which may be in conflict with the contents as stated herein for Acute Emotional Disorders Complicating Maternity Care.

2. Increasing evidence has come to the attention of the Office for Dependents' Medical Care indicating a need for clarification of the extent to which the Government will pay in the case of eligible dependents who develop acute emotional disorders complicating pregnancy or constituting postpartum psychosis occurring within the authorized six (6) weeks postpartum period. This clarification is in consonance with the provisions of the Program relating to complete obstetrical and maternity services.

3. Due to the separate contract arrangements relating to payment of hospital and physician charges, this subject requires separate consideration for the procedures relating to payment of the care identified in the preceding paragraph.

4. Care Authorized

a. Antepartum Period

(1) Hospital Services: In-hospital care may be authorized for limited periods when such cases constitute an actual complication jeopardizing pregnancy. Requests for payment of in-hospital care of the acute phase of the emotional disorder arising during pregnancy must be accompanied by certificate(s) signed by the attending physician and/or the physician providing psychiatric skills. This certification of clinical facts must be in sufficient detail to establish the nature of the acute phase of the emotional disorder which is considered to jeopardize the pregnancy. Payment for the acute phase of the emotional disorder will be limited solely to services required for its management.

(2) Physician Services: To preclude delays in payment and prolonged correspondence, requests for payment of physician services (DA Form 1863) related to in-hospital management of the case submitted by the attending physician and/or the physician providing psychiatric skills must show the identical certification as required by paragraph 4a(1), above.

b. Postpartum Period

(1) Hospital Services: To be payable under the Dependents' Medical Care Program, the admission for in-hospital care of postpartum psychosis must have occurred during the authorized six (6) weeks postpartum period. The maximum Government liability will be limited to the management of the acute phase of the postpartum psychosis.

For this service to be payable, claims must be accompanied by certificate(s) of the clinical facts signed by the attending physician and/or the physician providing psychiatric skills. This certification must indicate that an acute phase of the postpartum psychosis existed at the time of admission to the hospital and that the acute phase extended through the entire period covered by the claim submitted.

(2) **Physician Services:** Requests for payment of physician services related to in-hospital management of the case identified in paragraph 4b(1), above, must be accompanied by the same certification as indicated in that paragraph. This certification must accompany the DA Form 1863 (Claim) submitted by the attending physician and/or the physician providing psychiatric skills.

5. **Care Not Authorized**—The contents of this letter do not authorize payment for:

a. **Pseudocyesis** or its management as this condition has never constituted authorized care under the Dependents' Medical Care Program.

b. **Outpatient care** for acute emotional disorders.

6. Administration by Contractors

a. Antepartum Care

(1) **Contractors Paying Hospitals**—When a DA Form 1863 (Claim) submitted by a hospital is accompanied by the certification required in paragraph 4a(1), above, and the claim is otherwise complete and payable, the contractor may effect payment without further reference to this office when the hospitalization does not exceed 21 days.

(2) **Contractors Paying Physicians**—When the DA Form 1863 (Claim) submitted by a physician is accompanied by the certification required in paragraph 4a(2), above, and the claim is otherwise complete and payable, the contractor may effect payment without reference to this office when the hospitalization does not exceed 21 days. The physicians' fees will be paid in accordance with their usual charges or those set forth in the applicable Schedule of Allowances, whichever is less, or as determined under the applicable contract provisions (Special Report).

b. Postpartum Care

(1) **Contractors Paying Hospitals**—When the DA Form 1863 (Claim) submitted by a hospital is accompanied by the certification required in paragraph 4b(1), above, and the claim is otherwise complete and payable, the contractor may effect payment without reference to this office when hospitalization does not exceed 21 days.

(2) **Contractors Paying Physicians**—When the

DA Form 1863 (Claim) submitted by a physician is accompanied by the certification required in paragraph 4b(2), above, and the claim is otherwise complete and payable, the contractor may effect payment without further reference to this office when hospitalization does not exceed 21 days.

c. Unusual Cases Extending Beyond 21 Days

—In those exceptional instances where required management of the acute phase of the emotional disorder (antepartum or postpartum) is expected to exceed 21 days, prior approval for payment of any additional care in excess of 21 days must be obtained from the Contracting Officer, Office for Dependents' Medical Care. The request from the hospital for prior approval, as explained in paragraph 7, below, must be accompanied by a report of the clinical nature of the acute phase necessitating the extension. Our experience indicates that necessity for such care beyond 21 days is most uncommon.

7. Procedure for Requesting Extension of Care Beyond 21 Days

a. Upon admission of a maternity patient for management of an acute emotional disorder under the Dependents' Medical Care Program as stated above, the hospital administrator should immediately contact the attending physician and/or physician providing psychiatric skills to ascertain the length of hospitalization required for management of the acute phase.

b. When it is indicated that hospitalization will exceed 21 days, the hospital administrator should immediately obtain from the physician and/or physician providing psychiatric skills, a report as required by paragraph 6c, above, containing the following information:

(1) The name of the dependent; (2) Date of admission; (3) Diagnosis; (4) Nature of acute problem; (5) Prognosis; (6) Service members name; (7) Serial number; (8) Branch of service; (9) Duty station; (10) Name of the physician(s); (11) Length of time for which extension of management of the acute phase at government expense is requested, with justification therefor.

c. Both the request for extension and the report will be forwarded directly to the Contracting Officer, Office for Dependents' Medical Care, Office of The Surgeon General, U. S. Army, Washington 25, D. C. Because of the shortness of time, both the request for extension and the report must be submitted by the end of the first ten (10) days of hospitalization and be forwarded by Air Mail, if more expeditious. A copy of the request for extension only, will be sent by the hospital administrator to the concerned contractor

paying hospitals and the concerned contractor paying physicians, respectively.

d. In those exceptional cases where extensions of time beyond 21 days are authorized by the Contracting Officer, Office for Dependents' Medical Care, the hospital and the contractors paying hospitals and physicians will be notified simultaneously. In these cases, the DA Form 1863 (Claim) submitted by the hospital and physician(s) for payment must have attached thereto a copy of the Contracting Officer's authorization.

e. When an extension of time is not authorized, the Contracting Officer, Office for Dependents' Medical Care, will notify the hospital and the concerned contractors paying hospitals and physicians of the date when the Government's liability for payment did, or will, terminate.

Ohio Society of Internal Medicine Reports on Annual Meeting

The Ohio Society of Internal Medicine held its annual meeting in Cincinnati, Ohio, January 21, 1959, at the Netherland-Hilton Hotel and the United States Veterans I Administration Hospital, Cincinnati, Ohio. The Ohio Society of Internal Medicine represents 261 qualified Internists of the State of Ohio and holds its meetings annually in conjunction with the Regional Meeting of the American College of Physicians. The organization presented as a concluding part of the regional meeting of the American College of Physicians, a panel discussion on the "Status of the Internist in Medical Care Plans." This part of the program was presented by the Ohio Society of Internal Medicine upon the invitation of Dr. A. Carlton Ernstene, Governor of the American College of Physicians for Ohio.

The following officers at present are serving on the Board of Trustees: Arnoldus Goudsmit, M. D., President, Youngstown, Ohio; George J. Hamwi, M. D., vice-president, Columbus; Leonard P. Caccamo, M. D., Youngstown, Secretary-Treasurer; O. W. Clarke, M. D., Gallipolis; R. Franklin Jukes, M. D., Akron; J. Harold Kottee, M. D., Cincinnati; L. P. Longley, M. D., Cleveland; Maurice A. Schnitker, M. D., Toledo; Joseph M. Wilson, M. D., Dayton.

This Society was founded at an organizational meeting at Columbus, May 13, 1957, and was incorporated as a corporation not for profit on May 23, 1958. Its purposes as established in Article III of its by-laws are as follows:

1. To promote continuing improvement in the standards of medical care in making available to

OSMA Golfers To Play In Cleveland, June 18

The 1959 tournament of the Ohio State Medical Golfers' Association will be held on Thursday, June 18, at the Acacia Country Club, Cleveland.

Members, or others interested, may obtain details regarding the tournament from Mr. Robert W. Elwell, executive secretary, Toledo Academy of Medicine, 3101 Collingwood Blvd., Toledo 10, who serves as secretary of the golfers' association.

the public the benefits of the advances of modern medical science.

2. To foster the recognition of the Internist as a trained specialist in the field of diagnosis and the medical management of disease so that his services may be utilized to the fullest, and to the best interests of the patient.

3. To promote research in the field of improved distribution of medical care, and to study private and public (self-sufficient and tax-supported) health services and health insurance plans, so that it may contribute most effectively toward the provision of the best medical service without needless expense and without detriment to the welfare of the patient or of the physician.

4. To maintain and advance high standards of medical education and clinical research in cooperation with the American College of Physicians.—L. P. Caccamo, M. D., Secretary-Treasurer (quoted from Bulletin of the Mahoning County Medical Society).

Cleveland Course in Gastroenterology Offered by Bunts Institute

The Frank E. Bunts Educational Institute affiliated with the Cleveland Clinic Foundation is offering a postgraduate course in gastroenterology. This course will be presented by staff members of the Cleveland Clinic Foundation and guest speakers, May 13 and 14. A courtesy luncheon will be served on Wednesday.

Due to limitation of auditorium capacity, registrations will be limited to 125. Acceptances will be made in the order of application.

The course will be held on the fourth floor of the North Clinic Building located at Euclid Avenue and East 93rd Street. Nearby hotels having comfortable accommodations are the Wade Park Manor, Park Lane Villa, and Alcazar Hotel. The University Center Motel is located directly opposite the Cleveland Clinic.

WHEN MORE THAN
MILD SEDATIVE
EFFECT IS DESIRED

Consequently, TENTONE is more useful than other ataractic drugs in two areas: (1) mild to moderate conditions—when more than mild sedative effect is sought, (2) middle range of moderate to severe cases—when less than psychopathology is involved.

Indications include ■ common anxiety-tension states ■ obsessive-compulsive behavior ■ neurosis ■ depression ■ situational anxiety and hysteria

And the emotional components of: ■ agitation ■ restlessness ■ tremors ■ insomnia ■ alcohol- and drug-withdrawal syndrome ■ hyperkinesis ■ prenatal anxiety ■ rheumatic disorders ■ dermatoses ■ menopausal syndrome ■ premenstrual tension ■ peptic ulcer, other g.i. disorders ■ asthma, other allergy ■ multiple sclerosis, arteriosclerosis ■ malignancy, other progressive diseases

POSSIBLE
POTENTIATION OF
ANALGESICS
AND NARCOTICS

Since tranquilizing drugs may potentiate the action of pain-relievers, sedatives, and barbiturates, they should be used with caution in conjunction with them, or to achieve a greater response to these drugs in various conditions when desired. They may also be useful in reduction of effective dosage to better tolerated, or non-habituating levels.

ADAPTABLE
LOWER DOSAGE
RANGES

Dosage must be individualized to severity of condition and response desired.

In mild to moderate cases: varies from 30 to 100 mg. daily.

In moderate to severe cases: from 75 to 500 mg. daily.

In psychotic or institutionalized patients, TENTONE may be useful as a substitute when toxicity precludes effective dosage of other phenothiazines, or as maintenance after hospitalization. Dosage may range from 100 to 1500 mg. daily in divided doses.

Supplied: 10 mg., 25 mg. and 50 mg. tablets



LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

AMA Atlantic City Session . . .

Ideal Location for June 8-12 Meeting Will Draw Physicians from All Parts of the Country; Many Ohioans Will Be Among Those on Program

HYPNOSIS, staphylococcal infections, blood cell disorders, space medicine, European spas, and aging are among the subjects to be considered at the 108th annual meeting of the American Medical Association June 8-12 in Atlantic City.

Some 450 physicians, many of them from Ohio, will present scientific papers or participate in panel discussions and symposiums during the meeting. In addition, there will be 387 scientific exhibits shown by physicians and 285 industrial exhibits prepared by pharmaceutical houses, medical equipment firms, and other business organizations.

Most of the scientific sessions, along with the exhibits, will be held in the Atlantic City Convention Hall. Some scientific meetings will be held in hotels.

Anniversary of Sections

Seven of the 21 sections of the scientific assembly mark their 100th anniversaries during the meeting. They are the sections on surgery, internal medicine, obstetrics and gynecology, experimental medicine and therapeutics, pathology and physiology, nervous and mental diseases, and preventive medicine.

Other features of the scientific program will include color television and motion pictures. Two films of special interest to be premiered deal with staphylococcal infections in hospitals and radiation protection in diagnostic radiologic examinations.

Ohio's delegates will meet with the House of Delegates and its 210 members throughout the week in the Traymore Hotel, headquarters for the meeting. The House will select a physician to receive the Distinguished Service Award at its opening session Monday morning, June 8. Winner of the Goldberger Award, given for outstanding contributions in the field of nutrition, will also be announced Monday. The winner will present the annual Goldberger lecture at the opening of the general scientific session Monday afternoon.

Dr. Louis M. Orr, Orlando, Fla., will be inaugurated president of the AMA Tuesday evening. The inaugural will be followed by a reception and ball. Lester Lanin and his 20-piece orchestra, internationally known dance band, will provide the music for the ball in Convention Hall.

Other Features

Other features of the meeting will include:

Meetings by the Woman's Auxiliary to the AMA throughout the week. Mrs. Frank Gastineau, In-

dianapolis, will be installed as president, succeeding Mrs. E. Arthur Underwood, Vancouver, Wash.

Art exhibits by the American Physicians Art Association in Convention Hall.

Special exhibits in the scientific section by high school students who won AMA awards in the National Science Fair, and by medical students and interns and residents who won prizes at the Student American Medical Association's annual meeting.

Mass Casualty

Military and medical preparedness for the management and care of mass casualties in case of war will feature the seventh annual National Civil Defense Conference which will be held in Atlantic City on Saturday, June 6, immediately prior to the opening of the AMA convention.

"The one-day program will highlight medical problems involved in nuclear warfare," said Dr. Harold C. Lueth, Evanston, Ill., chairman of the AMA Committee on Disaster Medical Care. "The program, unique since it will be presented entirely by the Army Medical Service, will dramatize the important fact that the medical and health professions can take positive action to minimize the impact of mass casualties if properly trained and organized," Dr. Lueth said.

For advance hotel and meeting registration information, contact the Convention Services Department, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

Hypnosis Board Does Not Have AMA Approval

The AMA's Council on Mental Health has announced that the "American Board of Medical Hypnosis," which presumably has set itself up as a certifying body for physicians using the technique, is neither connected with nor approved by the AMA.

A notice concerning this "board" was published in the *Journal of the American Medical Association*, January 3, 1959, but the Council said this does not in any way reflect AMA approval of the group.

The Council said it understands that "actually two or three such groups have been set up in the United States that seemingly allege in their announcements they are functioning in collaboration with the Association. . . ."

Columbus Academy Health Fair . . .

Exhibit Draws 110,000; Membership Assessment, Two Years of Planning Pays Big Dividends in Public Relations, Health Education, Good Will

MEASURED by any one of a half-dozen yardsticks, the Columbus Academy of Medicine's Health Fair March 25-29 paid tremendous dividends for the medical profession. Two years of careful planning along with a \$15 per capita assessment of the Academy's 850 members produced such results that 10,000 persons were turned away the last day because they couldn't get inside the big Veterans Memorial Building exhibit hall. The doors were opened at 1 P. M. the last day and by 4 P. M. the Academy had asked local radio and television stations to advise persons planning to attend the Health Fair not to do so because they wouldn't get inside the building by 6 P. M. closing time.

Thus, measured by an attendance yardstick, the success was established. Measured by its health education value, the fair was attended by more than 12,000 eighth grade school children from Columbus and Franklin County public, private and parochial schools, plus a group of school children from Dayton and Vinton County. The educational values extended also to 100,000 adults.

News Media Impressed

Measured by a wealth of newspaper items and editorials, and radio and television commentaries, the Academy scored a smash with the news media, which described the fair as superlative.

Measured by physician participation, the fair was outstanding. Of the 850 Academy members, 506 participated actively, serving on committees, helping to staff some of the 80 exhibits, acting as hosts, and many other duties.

The Academy's Woman's Auxiliary also contributed considerably, with auxiliary members, among other assignments, acting as guides for the 12,000 school children who viewed the exhibits in groups of 12 to 22. Eighth graders were selected to see the fair because they study general science.

The Health Fair was staged on a strictly non-commercial basis. The Academy leased the exhibit hall and then made exhibit space available to paramedical and auxiliary groups. No commercial exhibits were permitted. Exhibitors included 10 voluntary health agencies, the pharmaceutical, dental, nursing and veterinary medical

professions, Columbus Department of Health, Board of Education, U.S. Army Medical Corps and the Atomic Energy Commission, and the Columbus Hospital Federation.

AMA Cooperation Praised

Academy officials gave high praise to the AMA's Bureau of Exhibits for making available to the Academy 23 exhibits. The AMA exhibit on "Life Begins" and the Dominican Republic's Juno topped all exhibits in popularity. Juno is the life-sized, transparent plastic model of a woman. All her interior organs and circulatory system are visible. Each organ and part of the body lights up while its function is explained to the audience by means of a tape recorder. "Life Begins" consists of plastic-encased, life-sized models depicting conception and the reproductive process.

A preview of the fair was held the evening of



OSMA Past-President Woodhouse congratulates the Columbus Academy of Medicine for its Health Fair, held in March when Dr. Woodhouse was President of the Association. Opening ceremonies are shown here.

March 26, with Columbus' Mayor Jack Sensenbrenner cutting the opening ribbon, Academy President James L. Henry welcoming the guests and OSMA President Woodhouse delivering a message of congratulations.

The fair was opened to the public afternoons

Two Popular Exhibits at Columbus Health Fair



Probably the most popular attraction at the Columbus Academy of Medicine Health Fair March 24 to 29 was Juno, the famous transparent replica of the human body that enables lay persons to gain valuable knowledge of the locations and functions of the various organs and systems. Another exhibit exceedingly popular was the AMA's famous "Life Begins" exhibit, in which models scaled to life show the reproductive process.

and evenings, with the mornings and early afternoons given over to school tours.

Foundation Formed

The special assessment to finance the show was transferred to the Columbus Academy of Medicine Educational Foundation, Inc., which was organized principally for the fair but will be continued in event other projects are undertaken.

The Foundation is responsible directly to the trustees of the Academy of Medicine. Under the table of organization, a 1959 Health Fair Committee was appointed, and W. "Bill" Webb, executive

secretary of the Academy, was named managing director of the fair.

Other committees were appointed for exhibits, Veterans Memorial arrangements, budget, pre-fair open house, and publicity, promotion and school tours.

Fair promotion includes a complete publicity kit, including news releases, radio and television spots and TV slides, and prepared interviews. Literature and letters were distributed to the schools and to church groups.

Placards announcing the fair were displayed in

The Public's Response Was Past All Expectation



Shown at top are some of the 110,000 residents of Columbus and Franklin County who visited the Columbus Academy of Medicine Health Fair, held in the Veterans Memorial Building. Particularly of interest to the more than 12,000 school children who attended was the exhibit dealing with a career in medicine (bottom).

all Academy members' offices, in restaurants and other locations, billboards were used and several types of flyers were distributed widely.

As a follow-up, the Academy is conducting an essay contest in the 50 schools that sent classes to the fair. Each pupil may submit an essay of 400 words on one of two subjects—"What I Have Learned from The Health Fair" or "What I Liked Best at the Health Fair." The Academy allocated \$400 to provide a \$5 first prize and a \$3 second prize for winners in each of the 50 schools.

Movie of Fair Planned

As another follow-up, the Academy is having prepared from color movies of the fair a 20 to 25-

minute sound film in which the commentary will describe how the fair was planned and staged, and the results.

The Columbus press and many prominent community leaders have asked the Academy to take the leadership in establishing a permanent health museum in Columbus. An Academy committee is studying the feasibility of such a museum, and will report its findings in September. As an alternative, consideration is being given to staging a health fair every four or five years.

These studies were strongly encouraged by the reception given the fair. A *Columbus Dispatch* editorial stated: "Few public service events staged in Columbus and Franklin County in recent years

Exhibits Were Graphic and Appealing to Laymen



This exhibit depicting an open heart operation was particularly well received because of the real-to-life atmosphere of the exhibit (top). Health Fair visitors also gained considerable knowledge of the kinds and extent of medical quackery (bottom) which is rampant in the nation today.

have gained such widespread support and commendation as the Health Fair, sponsored by the Columbus Academy of Medicine * * *."

"It is recognized that such an event is costly to stage and that many physicians and others were

taken away from busy schedules to participate in the program, but the value derived would seem to be well worth the expense and effort."

The *Ohio State Journal* said in an editorial, "Calls for an encore were heard even before the

School Youngsters Toured Exhibit in Groups



Another popular exhibit at the Health Fair was this AMA exhibit (top) illustrating with plastic models just what is involved in the breathing process. Also well received was the poison control exhibit (bottom) which illustrated how seemingly harmless household items and patent drugs can be toxic.

curtain dropped on the show now being hailed as exceptionally successful."

Fair Appreciated

In a letter of appreciation in which he described the fair as "one of the finest pieces of public education I have ever been privileged to see," Jerome D. Folkman, Ph. D., D. D., rabbi of Temple Israel in Columbus, wrote:

"For a long time I have been concerned about the increasing chasm between the helping professions and those they seek to serve. The problem of communication between them has grown in-

creasingly difficult and I have not witnessed too many efforts to bridge the gap. What you have done is an outstanding demonstration of what can be done in this regard. I do hope that other activities of this sort will be presented from time to time."

Those comments are typical of the many letters of appreciation and newspaper editorials concerning the fair.

All this was done without seeking government funds, without public solicitation and without commercialization.

Ohio Medical Indemnity . . .

Articles of Interest to OSMA Members Regarding Ohio's Blue Shield Plan Will Be Published Monthly in The Ohio State Medical Journal

By R. DEAN DOOLEY, M. D.

Director, Physicians' Relations Department, Ohio Medical Indemnity,
3370 N. High St., Columbus 14, Ohio

THE editor of *The Journal* has generously offered me space to present the Ohio Medical Indemnity story to our readers. It shall be my purpose to make my offerings brief, readable, interesting, informative and factual. I recognize the foregoing promise is a big order, but one thing I can positively guarantee—I can be brief. I shall ask only three minutes of your reading time and if you find the time has not been profitably spent, you can pass the next issue.

Ohio Medical Indemnity has inaugurated a Physicians' Relations Program and it is my good fortune to have the opportunity to head the department. We believe we have an important story to tell. In fact, we believe as one of the commercial insurance companies asserts in its advertising material, the reading of the OMI story may well be the most important thing you do.

The continued successful operation of the voluntary plans is vital to the future of organized medicine, and the effort of every physician in Ohio who believes in the free enterprise system, will be required to keep our plan an effective servant of our patients.

That there is an interest in our Blue Shield is attested to by the fact that at a meeting of the Huron Medical Society in New London on one of the vilest weather nights in my experience, 20 physicians of a total membership of 27 were in attendance to hear a discussion on the economic phase of medicine. Many of these physicians drove as far as 25 miles in a raging blizzard to reach the meeting place. One drove 55 miles to be present. They manifested an intense interest as indicated by intelligent and penetrating questions. The discussion was animated and developed a wealth of information, which will be helpful to me in conducting a program of physicians' relations in this state.

The Butler County Medical Society had a meeting recently in which the program consisted of panel discussions on prepayment insurance. The panel was moderated by an industrialist and we had as speakers the regional director of the United Mine Workers' Welfare Fund, the personnel director of a large industrial firm, and I represented

Editor's Note:

As Dr. Dooley has stated, *The Journal* will make available each month space for information regarding the activities of Ohio Medical Indemnity, Inc., Ohio's Blue Shield plan, which was organized by the Ohio State Medical Association and is actively sponsored by the association. We believe that Ohio physicians should be given an opportunity to know more about OMI and to keep up to date on its extensive program. In addition to reading the articles as they appear in *The Journal*, we hope that members will contact their County Medical Society program committee, urging that Dr. Dooley or others from OMI be invited to discuss OMI activities at an early meeting of the medical society.

organized medicine. It was a splendid turnout of the membership and interest was at a high pitch.

These are encouraging signs and indicate to me without doubt that the medical profession is attempting to catch up at long last on the economic approach to the practice of medicine.

I would like to assure county society program chairmen that this department will be in a position to assist them in preparing programs of social and economic interest for their medical society meetings. Please feel free to contact us for any help in this connection you may deem necessary.

Dr. G. Douglas Talbott, recently was named outstanding young man of 1958 by the Dayton Junior Chamber of Commerce when that organization presented him the Jaycee Distinguished Service award.

New deputy secretary general of the World Medical Association is Dr. John M. Bishop, former U. S. Public Health Service officer and recently practicing physician of Bellevue, Wash., who will assist Dr. Louis H. Bauer, secretary general of the WMA.

New Drugs . . .

Research and Development—Keys to Many Drugs Making Their Debut in The Doctor's Bag or Druggist's Shelf—Are Time-Consuming and Costly

TO find and develop new drugs is a costly, complicated, time-consuming procedure. Today's useful compounds are the result of the efforts of highly-trained scientists working in many different fields. Much of the work of these men, in turn, is based on experience recorded over the years by other investigators in the same or in allied fields.

The development of new pharmaceuticals occurs through an exchange of services, ideas and information between industry and the medical profession, too.

Research performed outside the industry is brought through the development stage in pharmaceutical laboratories. Drugs developed in industry laboratories are tested by clinicians working in hospitals, universities, medical schools and clinics.

Just as practicing physicians are dependent on the advertising and promotional efforts of pharmaceutical companies for education on new products, so research directors in pharmaceutical laboratories are dependent on the guidance of the medical profession to determine what lines of research to follow.

Research and development is an expensive process. In 1956, the ethical pharmaceutical industry put \$110 million into its research and development effort. The research budget totaled \$127 million for 1957. Approximately 10 per cent of the 1957 budget was earmarked for use outside the companies' own laboratories: \$6,140,000 to research institutes, foundations and hospitals; \$4,500,000 in contracts, grants and fellowships to educational institutions; and \$2,000,000 for commercial laboratories and consultant fees.

In addition to the research budgets, manufacturers reported capital expenditures for the purchase of equipment and expansion of plant facilities for drug or medical research and development of \$12 million in 1956, and an estimated \$19.2-million for 1957.

To obtain the foregoing figures, three different activities were included in the definition of research and development:

1. Basic research: planned search for new knowledge, whether or not the search had reference to a specific application.
2. Applied research; application of existing

EDITORIAL NOTE:

The pharmaceutical industry is as highly competitive as any that can be named. Evidence is that that competition forces the industry to do almost as much research to achieve cheaper production and marketing as it does to develop new or better products. Penicillin, streptomycin and cortisone, expensive indeed when they first came on the market, have reached a reasonable price level with the operation of competitive production and marketing.

Many a physician, when he hands the patient a prescription, is met with a question like this: "Is this one of those expensive drugs, doctor?" The question is loaded, and two minutes of missionary work at this point may do wonders for the patient.

The accompanying article is presented in lay terms deliberately so the doctor may relay parts of this information to his patients in their own language. It is excerpted from a pamphlet entitled *Facts About Pharmacy and Pharmaceuticals*, published by the Health News Institute. Previous articles in this series appeared in the January, February, March and April issues.

knowledge to problems involved in the creation of a new product or process, including work required to evaluate possible uses.

3. Product improvement: application of existing knowledge to problems involved in the improvement of a present product or process.

Patents

The patent system has played an important role in the development of new and improved drugs. This is significantly true in the United States. This system, which permits patenting of new compounds as well as methods of production, has greatly encouraged risk-taking, and has strongly catalyzed initiative and research. It makes possible a fair return on the millions of dollars that a corporation may spend on the search for new drugs.

In the past these earnings from successful research have been plowed back into further expansion and development. Countries without an

enlightened and strong patent system have not experienced this progress.

The Problem

As a basis for pharmaceutical research, there is always a medical problem. What particular research project a pharmaceutical laboratory undertakes depends in part on the talents and abilities of its research people, the know-how of its manufacturing organization, and the physical facilities with which the plant is equipped. The development of a new vaccine, for example, is most likely to be undertaken by a company staffed with bacteriologists, whose production facilities are capable of handling a biological product.

Each problem must be approached in a specific way. Discovery of the substances that play a key role in animal metabolism is the object of research on deficiency diseases. The approach to infectious disease is quite different. The problem here is to find some substance that will kill or inhibit the growth of the disease organisms, or neutralize the effect of foreign or offending substances—not just in a laboratory dish or animal, but within the human body without harming the patient.

The Idea

Since records are invaluable, a library plays a strategic part in any organization that has an integrated research program. Future research is based in good part on the results of past investigations.

The libraries of most pharmaceutical research organizations contain international chemical, pharmaceutical and medical journals; trade papers, reference books, monographs, reports, patent information—to name but a few items. Research workers turn to the library for information and, at times, may need a complete search of the literature on a subject.

It is a long road from the idea for a new drug to the marketing of a new preparation for the treatment of disease. In highly simplified terms, however, it can be said to proceed in three states—research, development and production—using the talents of highly skilled men and women in the fields of chemistry, pharmacy and medicine.

Chemical Research

From a chemical standpoint, there are two major approaches to a new drug.

1. The isolation and identification of drugs from natural sources. These products may be of animal origin, such as the hormones; of plant origin, such as morphine and codeine from opium; or of microbiological origin, such as the antibiotics.

The discovery and development of an antibiotic

offer a good example of this approach. One pharmaceutical laboratory started its intensive search for new antibiotics in 1947 with a screening operation that built up to a team of 55 scientists. This team tested five to six thousand samples of soil a month which had been collected from all over the world, looking for organisms with antibacterial activity. In two and a half years of searching, during which 100,000 cultures from soil samples were tested, only 76 showed any antibiotic promise. From this multi-million dollar project, one therapeutically-useful antibiotic was developed. The mold that generated it lay in a spoonful of earth from an Indiana farm.

The development of cortisone and ACTH is another example. This was probably the biggest gamble ever placed upon medical research. It has been estimated that upward of \$25 million was spent, in the five years between 1946 and 1951 alone, by pharmaceutical companies for research in the development of these and other adrenal cortex hormones related to cortisone. Moreover, assuming any profit at all was realized on the investment during those years, its percentage would have to be expressed as a very small decimal. But ultimate benefit to the public justified the risk.

2. The development of new synthetic organic compounds having therapeutic value. This involves investigation of the relationships between the structure of a chemical and its physiological action. How a drug affects the human body or what it does to a disease organism is a function of its structure, and very small changes in chemical structure may modify or completely alter its effect. These modifications may mean replacing one chemical group with another at a specific point in the compound's molecule. It is something like adding a room to a house, or rebuilding an existing wing.

In the search for an effective antituberculosis drug, one laboratory considered 8,000 chemicals. Of these, 5,000 were actually synthesized or otherwise produced and tested on culture media. About 1,000 of the compounds were tested in animals before the discovery, coincidentally with another laboratory, of the effectiveness of the compound isoniazid in 1951.

Other objectives in synthetic chemical research are the development of methods of synthesizing naturally occurring products, such as penicillin, reserpine and the vitamins, and the improvement of processes for producing synthetic products.

Biochemical Research

Hand in hand with the research chemist, the biochemist investigates the action of drugs on body functions, and, in fact, on life processes. The

investigation of new drugs to control the metabolic disease, diabetes, furnishes a good example of this work. Recently, the use of radioactive isotopes in compounds to study chemical or biological activity in plants and animals has become a subject of interest. This has been particularly true in the study of drug metabolism and excretion, and in the field of nutrition.

Pharmacology

Administration of new chemicals to animals is a most important step in the development of a new drug. In the search for a new drug to control blood pressure, for example, a series of compounds would be administered to experimental animals in order to determine the one with the most desirable effect. When a new drug has been found with the aid of such a screening program, further study is necessary to find the optimum dosage.

When a drug with a desirable effect has been discovered, the pharmacologist must also determine whether any undesirable effects are associated with it, "Side effects" could interfere with the use of the compound for its primary purpose.

In addition, the pharmacologist must find out how toxic the drug is in doses greater than those which would be used in treating the disease. It is obvious that a new compound which would kill almost as readily as it would cure would be of no practical value in clinical medicine. The effect of the drug over a period of weeks or months must be determined, too, in order to ascertain whether administration over a long period of time might have an adverse effect.

Because drugs may have different effects on various species of animals, tests must be carried out on two or more species. All this is done prior to any administration of a new drug to human patients in order that the effect may be predicted as accurately as possible.

Bacteriology and Virology

Experimentally infected animals aid in the evaluation of both immunizing and therapeutic agents. Laboratory technicians administer new immunizing agents to normal animals and later "challenge" with appropriate infective agents in order to determine the degree of protection. In the case of new therapeutic agents, the normal animals are given an experimental infection and the new drug is administered in order to determine its effectiveness in treating the disease.

Clinical Research

After careful testing in animals in the laboratory, the most promising new drugs are sent to hospitals where clinicians interested in clinical research ad-

minister them cautiously to carefully selected patients.

Studies are set up in such a way as to deprive no patient of his right to the best established therapy available, nor to expose him to risks. Physicians in the clinical research department of a pharmaceutical company make the arrangements for these tests. They also correlate and evaluate the information received from the clinicians and act as an information and coordination center for the investigation.

Arrangements for the study of a new drug which showed promise of controlling epileptic seizures, for example, would be made in a hospital where patients are available for study under controlled conditions, and whose doctors are qualified to judge the value of the drug in comparison with therapy already in use. If the results of study of the drug in a few patients were successful, then the series of cases would be enlarged.

The number of patients to be treated and the time period of the clinical trials vary with the disease. Several years of study may be necessary to evaluate the effectiveness of an anticonvulsant drug for use in epilepsy because of the nature of the disorder, whereas a considerably shorter period may suffice to tell whether the course of an acute infectious disease, such as pneumonia, reacts favorably to a new drug.

Rigidly controlled studies in large numbers of patients are often necessary to evaluate drugs that alleviate symptoms or modify the course of disease without effecting a cure, in order to make sure the response is actually caused by the drug and not merely by coincidence.

"Blind studies" involving new drugs, accepted drugs, and completely inactive substitutes (placebos) with statistical analysis of the results, are set up. Since neither the clinician nor his patient knows when the drug in question is being given or when the accepted drug or inactive tablet has been substituted for comparison, safe and competent planning by the clinical research department of the pharmaceutical laboratory is of vital importance, and such studies are carried out with extreme care.

Research and Development

The dosage form in which a medicinal agent is prepared for clinical use is far from a matter of caprice. Choice of tablet or capsule, liquid or ointment, oral or injectable form is based on the chemical and physical properties of the drug, as well as its biological activity.

Pharmacists working in research and development must consider information supplied to them by chemists and pharmacologists concerning the

properties and action of the drug, as well as information from physicians concerning the most acceptable form from a clinical standpoint.

Stability is a most important consideration, for many medicinal chemicals gradually lose their biological activity over a period of time. The compatibility of two or more ingredients in a pharmaceutical preparation must be tested to determine whether they react chemically with each other. The effect of temperature and humidity on the final product must be considered in anticipation of the variety of conditions under which the preparation might be stored.

The esthetic problem of whether the new pharmaceutical will be acceptable to the patient must be considered. One laboratory testing the effect of anti-tuberculosis drugs on infected monkeys had the tablets made banana-colored so they could be given to the monkeys by mouth without the animals being aware of their presence in the fruit.

This is a relatively simple illustration of the obvious fact that medicine is of little value unless the patient can and will take it. With the same idea in mind, another company submits its pediatric forms to a junior "taste panel" to see if the preparation will be acceptable to young patients.

Another company invested more than \$1,500,000 in development of a sulfa drug in liquid form capable of releasing medication over a twelve hour period. Sulfas, ordinarily given every four hours, were somewhat of a problem for parents to administer to balky youngsters. The development of a sustained-release liquid cut to one-third the number of arguments over taking the medicine, for it could now be given twice a day instead of six times a day.

Chemical Pilot Plant

New drugs or new processes of manufacture rarely go into production directly from the research laboratory. Chemists and chemical engineers must first appraise the problem of doing on a large scale what has been done previously only in a test tube. They must develop sources of crude materials, decide what grade of intermediates may be used, what the critical limits of impurities will be, and determine all physical constants on the products to be prepared.

Next, detailed directions for manufacture must be drawn up. These include the procedural steps, how fast reagents can be added, the temperature and timing for reactions, and the type of mixing required. This must all be done with an eye toward keeping the cost of operations at a minimum. Economy requires studies on solvent and by-product recovery. Safety precautions must be considered thoroughly, too.

Fermentation chemistry, with its precious yield of antibiotics, vitamins and hormones, is an example of how industrial science bridges the gulf between discovery and practical utilization, between the first understanding of a scientific principle and its controlled application. It may be picturesque to imagine pharmaceutical fermentation as a modern version of the primitive arts of brewing and cheese-making, and it may be interesting to ponder whether the antibiotic era might have dawned centuries ago if only scientists had sensed the microbial warfare which seethed beneath their feet, but there is little realism to such notions.

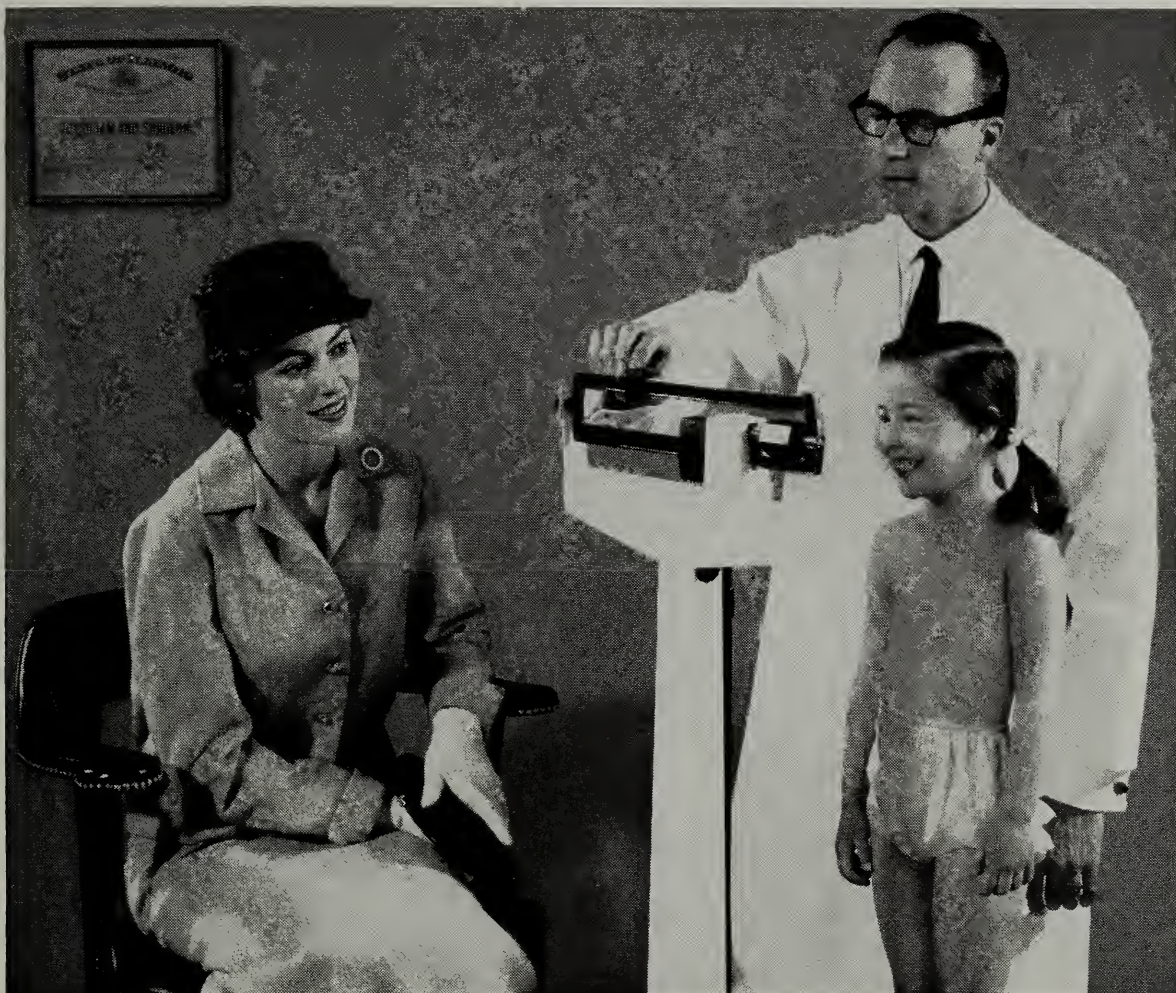
Had some 19th-century Sir Alexander Fleming discovered penicillin, industry would have been in the same powerless position as a Renaissance workshop faced with the problem of building airplanes from the plans of Leonardo da Vinci. Just as man's flight had to await a practical means of power, so medicine's conquest of many diseases had to await modern methods of drug manufacture, testing and control.

Competition and Research

Research laboratories in the pharmaceutical industry are constantly at work not only in the search for new and different drugs, but also in a search for drugs which may be better than the very ones which their own company is marketing. This is done in the realization that if they do not find the drug which will make their product obsolete, a competitor will. Competition in the pharmaceutical industry is keen, for each laboratory knows that other laboratories are working on projects similar to theirs and that any new pharmaceutical development which is marketed may be followed in a short time by one that is equally good, if not better.

A recent comment in the *Journal of The American Medical Association* refers to the competition among manufacturers:

"The pharmaceutical industry is as highly competitive as any that can be named. This industry is very much aware that the physician-patient relationship is such that the physician does consider the matter of price if there is any choice open to him in selecting prescriptions. All of the evidence is that this severe competition forces the industry to do almost as much research to achieve cheaper production and marketing as it does to develop the new or better products. . . . As soon as just one producer of these products is able to produce and market them more cheaply, he will certainly do so, with the object of forcing his higher priced competitors out of the market. This will cause other producers to accelerate efforts to improve their own production and marketing techniques. Further price cuts, with eventual stabilization at a



Underweight Children Gain and Retain Weight with Nilevar[®]

One of the most convincing evidences of the anabolic activity of Nilevar, brand of norethandrolone, has been its ability to improve appetite and increase weight in poorly nourished, underweight children.

A highly important feature of the weight gain thus produced is that it is not ordinarily manifested by deposition of fat but as muscle tissue resulting from the protein anabolism induced by Nilevar.

Anorexia and "Weight Lag" Study—Brown, Libo and Nussbaum have reported* consistent and definite increases in rate of weight gain in eighty-six patients, ranging in age from 7 weeks to 15½ years. This beneficial action of Nilevar was observed in the patients with organic and traumatic disorders as well as those whose only complaints were poor appetite and/or persistent failure to gain weight.

In this study, the weight gained was not lost

after discontinuance of Nilevar therapy although many patients did not continue the sharp gains effected by the drug.

The authors are of the opinion that Nilevar is a highly useful anabolic agent for influencing weight gain in underweight children.

When Nilevar is administered to children a dose of 0.25 mg. per pound of body weight is recommended and continuous dosage for more than three months is not recommended.

Nilevar is supplied as tablets of 10 mg., drops of 0.25 mg. per drop and ampuls of 25 mg. in 1 cc. of sesame oil. Further dosage information in Searle Reference Manual No. 4.

G. D. Searle & Co., Chicago 80, Illinois.
Research in the Service of Medicine.

*Brown, S. S., Libo, H. W., and Nussbaum, A. H.: Norethandrolone in the Successful Management of Anorexia and "Weight Lag" in Children, Scientific Exhibit presented at the Annual Meeting of the American Academy of Pediatrics, Chicago, Oct. 20-23, 1958.

lower level, will be the result. Penicillin, streptomycin, and cortisone have all had price histories that seem to demonstrate the validity of this conclusion."

Market Research

At a very early stage in a new product's development, the market research department is usually asked to determine the probable sales potential for the product and also the degree of competition in the market. Such studies may indicate that the product would not produce a sales volume of sufficient magnitude to warrant its ultimate manufacture and marketing. In a number of leading pharmaceutical firms, studies of this type are becoming concurrent with the product idea. This procedure helps to prevent needless duplications from reaching the market, and often saves a manufacturer further costs of research and development on poor market risks.

Some pharmaceutical preparations, however, whose use may be limited to emergencies or unusual medical situations, are marketed regardless of sales potential, often at a loss to their manufacturer, in order that they may be available to the physicians and their patients who need them.

Dr. McCann Reappointed to Medical Board for Seven-Year Term

Dr. John N. McCann, Youngstown, president of the State Medical Board, has been reappointed to his third seven-year term by Governor Michael V. DiSalle. His current term runs to March 18, 1966.

Dr. J. O. Watson, Columbus, osteopathic member of the Board, was reappointed for a four-year term ending March 18, 1963.

Other members of the Board are Dr. W. M. Hoyt, Hillsboro; Dr. Donald F. Bowers, Columbus; Dr. Horace B. Davidson, Columbus; Dr. John D. Brumbaugh, Akron; Dr. Frederick T. Merchant, Marion, and Dr. Harris D. Iler, Cleveland. Dr. H. M. Platter is secretary.

Diagnostic Roentgenology

During the week beginning June 15, 1959, the second annual Refresher Course in Diagnostic Roentgenology will be held at the Cincinnati General Hospital. The course covers various aspects of diagnostic roentgenology with emphasis on fundamentals. Instruction will be given exclusively by members of the Radiology Staff. Enrollment is limited to radiologists and radiology residents. Tuition is \$150. Further information and application forms may be obtained from Dr. Benjamin Felson, X-ray Department, Cincinnati General Hospital, Cincinnati 29, Ohio.

Say Forand Bill Put on Shelf Temporarily

HAS the Forand Bill, HR 4700, to provide hospital and nursing home care for persons 65 or over, participating in the Social Security Program, been temporarily sidetracked? Some say this is the case, pointing to the fact that it was not included among bills to be reviewed by a special subcommittee of the House Ways and Means Committee, charged with the responsibility of studying Social Security measures.

Among the four Democrats and three Republicans on the special Ways and Means Subcommittee is Congressman Jackson E. Betts, Findlay, representing the Eighth Ohio Congressional District and former speaker of the Ohio House of Representatives.

Although hearings may not be held on HR 4700 this year, consideration of the proposal in 1960 appears to be inevitable.

AMA Announces Permanent Committee on Hypnosis

A Committee on Medical Use of Hypnosis has been appointed by the American Medical Association, with Dr. Harold Rosen, Baltimore, as chairman. Other members are Dr. Zigmond M. Lebensohn, Washington, D. C., and Dr. Louis J. West, Oklahoma City. All three are psychiatrists.

The committee is part of the AMA's Council on Mental Health, which last summer prepared a report on the medical use of hypnosis. The report, adopted by the AMA's House of Delegates, said hypnosis may be regarded as a valuable therapeutic adjunct in certain medical situations.

Dr. Rosen, in an interview reported in the March 23 *American Medical Association News*, said hypnosis should be introduced into a medical school course whenever its use as a sedative, analgesic or anaesthetic may be of value. Thus, the use of hypnotism might be taught as part of instructions in obstetrics, orthopedic surgery or burn treatment.

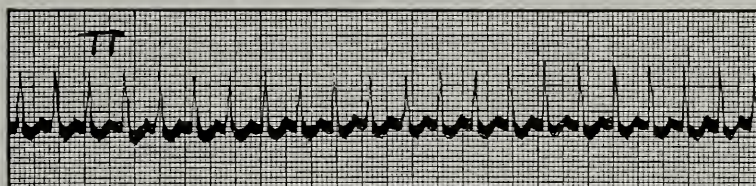
He emphasized that a background in psychodynamics is essential for physicians who wish to use hypnosis, adding that medical schools are doing more these days to give this type of instruction.

He deplored the "quick courses" in hypnosis which are being offered by various traveling groups to physicians, and believes that graduate courses in hypnosis should be conducted by medical schools themselves.

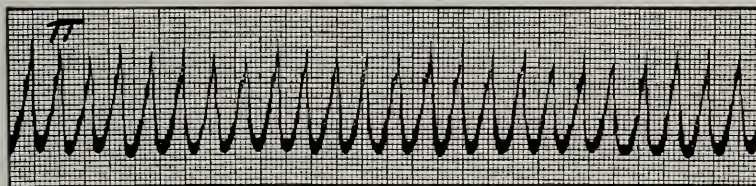
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of Vistaril as compared to other antiarrhythmic drugs in general use has been noted by investigators.

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PARENTERAL DOSAGE: 50-100 mg. (2-4 cc.) I.M. stat., and q. 4-6 h., p.r.n.; maintain with 25 mg. b.i.d. or t.i.d. In acute emergency, 50-75 mg. (2-3 cc.) I.V. stat.; maintain with 25-50 mg. (1-2 cc.) I.V. q. 4-6 h., p.r.n.

ORAL DOSAGE: Initially, 100 mg. daily in divided doses until arrhythmia disappears. For maintenance or prophylaxis, 50-75 mg. daily in divided doses.

SUPPLY: Vistaril Capsules, 25 mg., 50 mg. and 100 mg. Vistaril Parenteral Solution, 10 cc. vials and 2 cc. Steraject® Cartridges. Each cc. contains 25 mg. (as the hydrochloride).

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References: 1. Burrell, Z. I., et al.: Am. J. Cardiol., 1:624 (May) 1958. 2. Hutcheon, D. E., et al.: J. Pharmacol. & Exper. Therap., 118:451 (Dec.) 1956.

*Trademark

Keogh Bill Over House Hurdle . . .

Tax-Deferment Bill of Vital Interest to Physicians Now In Hands of U. S. Senate; Arguments for Measure Are Listed Here; Write Senators

BY a substantial voice vote, the House of Representatives recently passed H.R. 10, the Keogh-Simpson bill providing for a tax deferral by physicians, attorneys, dentists, accountants and other self-employed persons participating in an approved retirement program.

It is believed that most Ohio representatives voted for the measure although there was no record tabulation of the vote.

The big question now is whether the Senate will act this year or hold off action until 1960 when budget matters may be more settled.

Write Ohio Senators

The AMA and the Ohio State Association have given active support to this proposed legislation.

Ohio physicians who are interested should write to Senator Frank J. Lausche and Senator Stephen M. Young, in care of the Senate Office Building, Washington, D. C., and express their interest in the final enactment of H.R. 10.

Arguments For Bill

Here are good arguments in favor of this measure, drafted by the American Thrift Assembly, an inter-organization of groups (including the AMA) interested in bringing about the enactment of Keogh-Simpson type legislation:

What Is the Purpose of the Bill?

H.R. 10 would permit a self-employed person to defer income tax each year on a portion of his own income to provide for his retirement. This part of income would be paid in voluntarily to a restricted retirement fund or as premiums on an insurance policy with retirement features.

Why Bill Is Necessary

High taxes and inflated living costs make it difficult for the self-employed person to set aside money for retirement, in the absence of tax deferments which are already available to corporation employees. In many instances, qualified young men are going on a payroll rather than striking out for themselves. The Keogh-Simpson Bill would help counteract this shift away from individual enterprise. More than thirty national organizations representing self-employed persons are supporting the bill.

How Much Could You Set Aside?

You could set aside annually up to \$2,500 or 10 per cent of self-employment income, whichever is less, but not more than a total of \$50,000 during your lifetime. An individual who has reached age 50 before the effective date is allowed to deduct an additional amount to help him build up an adequate interest in the fund or obtain more than a token annuity. Persons over 60 could defer taxes on a larger amount.

How Can You Invest in Order to Qualify?

Under the Bill, you may claim a deduction for an investment in: 1) a restricted retirement policy (life, endowment, or annuity policy, but deductions are not allowed for costs allocable to the portion for life insurance protection); or 2) a restricted retirement fund trustee with a bank.

Are Many People Penalized Now?

A surprisingly large number of people—about 10,000,000—are penalized by present tax regulations. Affected are farmers, physicians, dentists, barbers, funeral directors, osteopathic physicians, veterinarians, lawyers, chiropractors, optometrists, beauty shop owners, accountants, architects, engineers, industrial designers, chemists, ministers, many types of salesmen, writers, artists, actors, musicians, dancers, real estate and insurance brokers, independent filling station owners, investment counselors, taxicab operators, and a host of other independent enterprisers. Generally speaking, anyone who is subject to the self-employment tax for social security purposes, this includes physicians, would be eligible.

Social Security Not Sufficient?

Even if physicians were to be covered under Social Security at some future date, the Old-Age and Survivors Insurance program is intended to provide the minimum benefits necessary for a subsistence standard of living. The Keogh-Simpson Bill is intended to provide a second layer of income for retirement or survivorship purposes to complement Old-Age and Survivors Insurance benefits. This complement would raise the living standard of the recipient from the subsistence level to one that more nearly approximates that of his productive years.

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Physicians and Their Investments . . .

Chief Analyst for Large Investment Firm Offers Suggestions and Rules Which Should Be Followed by Anyone Who Is Buying Common Stocks

THE following remarks were made by Mr. Lucien O. Hooper, chief analyst of W. E. Hutton & Company, New York City, before a general session of the Ohio State Medical Association.

* * *

The subject assigned to me is "Physicians and Their Investments." The inference one might draw from this title is that the investment problems of physicians are unique.

That is true, I think, only in a limited sense. The doctor, because of his environment, may be exposed to a few more ideas than the average investor, and thus at times tempted to do more unusual and imprudent things; but broadly speaking I do not think you can put the investment personalities of doctors into any standard mould. Some are prudent and highly successful. Others are afflicted with a cupidity which makes them amazingly naive.

As for doctors, they have all kinds of investment personalities, and every investment problem encountered by investors who are not M. D.'s. They represent all types of investment and speculative talent, and all types of the lack of it. They have all kinds of investment weaknesses and both malignant and benign prejudices. What I am about to say, therefore, applies to almost anyone, not just physicians. It may be pitched a bit higher, merely because of your superior intelligence.

Some Simple Rules

This is not going to be an erudite talk; but I hope it will be a helpful one. You may think, at times, I am talking in plausible platitudes rather than imparting new ideas worthy of your attention. I would like to point out, however, that in investment arts, as in medical science, the important and significant things usually are fundamentally simple.

After nearly 40 years of practice as an investment counsellor, almost as long as a writer on investment and economic topics, I have come to the conclusion that there are a few simple rules worthy of constant consideration, especially by those who are seeking to build a fortune, or a retirement fund, through the common stock route. I hope you will bear with me while I outline some

of them—rules which are just as applicable to other people as to doctors.

Save Regularly

The first rule is to save regularly. Do not assume that because you have a capital of \$5,000 or \$10,000 or \$25,000 with which to start that you will be able to multiply this money into a competence without adding to your principal.

Many professional people read the "come-on" literature of investment houses, usually on the periphery of respectability, and find in it much folklore about how you could have gotten rich if you had bought something for 10c a share and sold it for \$500.

Practically every doctor is on the sucker list of some alleged investment house which has no idea of giving its clients a fair shake but which holds out a promise based on some phenomenal appreciation which might have been. Furthermore, practically everyone in the United States who is believed to have an income of \$10,000 or more is regularly solicited by so-called services which for \$2.00 or \$10 or \$25 a year will tell you exactly what to buy in order to get rich.

When you buy these services you usually get just about what you pay for. I would warn you, however, that many of them are written to sell and not to serve.

It is much less exciting to put \$100 a month or \$500 a month into a mutual fund and compound your dividends than it is to buy Sure Fire Uranium Consolidated at 10c a share and acquire half a pound of beautifully engraved paper.

In the long run, however, the chances are at least 10,000-to-1 that you will lose all of your money in Sure Fire Uranium, and the chances are at least 100-to-1 that if you put \$100 a month into a mutual fund for ten years and compound your dividends, that you will have \$20,000 at the end of the period.

Don't Spend Dividends

The second rule is never to spend a dividend. Reinvest all dividends. This is merely applying the principle of compound interest to your program of accumulation. It is amazing how fast you can accumulate money even if there is no appreciation in your principal, provided you can

obtain 4 per cent or 5 per cent interest and compound the interest back into principal.

Don't Trade Too Much

The third rule is do not trade too much. Buy stocks to have and to hold—like your wife. Once in a while, just for the fun of it, you may go out with one of these girls that you would not take home to mamma. Investments of the in-and-out type, however, usually are more amusing than profitable.

Years ago it was said that stocks are made to buy and sell. If they are made to buy and sell today, the public has not discovered this fact. At the recent rate of trading it would take about nine or ten years to trade in all the stocks which are listed on the New York Stock Exchange once.

Allowing for duplicate transactions, it may be estimated that at least 95 per cent of all the shares listed on the New York Stock Exchange will be owned by exactly the same people at the end of this year as at the end of the last. If you are a trader nowadays you are a very unusual person. Only a small minority of all the transactions on the New York Stock Exchange, or on any registered exchange, or on the over-the-counter market, are speculative trading transactions.

The ownership of common stocks never was as permanent as it is now and it is growing more permanent every year. The reason is that it has paid investors to hold their stocks rather than to do a lot of trading.


Watch the Taxes

The fourth point is that you must avoid, legitimately, of course, impoverishing taxes. What Uncle Sam takes, you do not save. In your investment affairs, fortunately, you pay voluntary rather than involuntary taxes. You do not have to pay a capital gains tax unless you take a profit. You do not have to buy a stock which pays a high dividend.

If you buy into the shares of companies which distribute only a small part of their earnings in dividends and plough back most of their earnings into property, you will be buying growth and you will not be paying taxes on your dividends. If you buy into the shares of companies which are growing regularly and ignore price, which after all is nothing more significant than the time incidence of supply and demand, it is not necessary for you to sell your growth stocks. You can live with them more or less indefinitely.

The Contrast

Contrast what has happened to investors in stocks like International Business Machines, Minnesota Mining, Smith, Kline & French and General Motors over the past twenty years with what



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has happened to people who have traded in and out of stocks.

Remember that to a very large extent you are a voluntary tax payer when you pay a capital gains tax, and that you are a voluntary tax payer when you own a stock yielding 7 per cent instead of a stock yielding 1 per cent. Remember too, that \$1,000 worth of dividends, if you are in the 50 per cent tax brackets, gives you only \$500 to reinvest. If the company keeps that \$1,000 and ploughs it back into the company instead of paying it out to you in dividends, it has \$1,000 of your money to reinvest, and not \$500.

Beware of Slickers

Fifth, beware of get-rich-quick ideas. The siren song of the unscrupulous or misdirected salesman is a tune to pleasant music if one is naive enough to believe that the moon is made out of green cheese. The risk is always commensurate with the profit possibilities and the odds are terribly against you even if you are getting a fair shake for your money—and usually you are not getting a fair shake.

I may be wrong, but I suspect that doctors and dentists are unusually good prospects for the less legitimate security salesmen. I know this formerly was true. The next time someone tries to sell you a get-rich-quick scheme just pinch yourself and say "he probably came to me because I am a physician."

I do not know what you doctors would think of me if I tried to practice medicine at home without a medical education. I am sure you do not find it helpful when a patient reads all the medical journals, studies all the pharmaceutical literature and uses proprietary medicines.

Yet in many cases my "patients" do practically that same thing when they study the Wall Street Journal, the Commercial & Financial Chronical, Forbes Magazine, Barron's, talk to all of the people they know who are "in the market" and take seriously the so-called investment services and the come-on literature.

Get Competent Advice

I am reaching toward my sixth point, which is that you should seek competent professional advice and not consult too many people. In many counsels there is confusion and there is a terrific temptation to consult too many people regarding financial matters. After all, one layman is just as likely to be right as another layman.

Professional advice in the matter of investments is as open to the public as professional advice in the matter of medicine. When you consult a legitimate investment advisor or a legiti-

mate broker the information you give him about yourself and your affairs is as confidential as that which he gives you when he becomes your patient. He is just as much of an expert in investments as you are in health and his errors in judgment are no more numerous than your errors. So my final point is that the physician above all people should seek professional advice and follow it.

Consider Your Objectives

I suppose some of you came here with the idea that I might make some investment suggestions. You will notice that I have not been making any specific recommendations of stocks to buy, nor have I been expressing any opinion about the probability of an advance or a decline in the stock market.

What stock you should buy and what stock you sell depends on your investment objectives, and many other things about you. You don't prescribe medicine until you have diagnosed the case; neither do I. I would sell the same stock in one investor's portfolio that I would buy for the list of another investor.

Can't Guess the Market

No one knows what the stock market is going to do. That depends more on "surprise" and "unexpected" factors than on what is obvious, written about, talked about and known now. More money is lost, and more money fails to be made, by trying to guess "the market" than in any other way.

A real investment program should seek to hedge itself, so far as possible, against unfavorable fluctuations. That can be done to some extent by "dollar price averaging." And "dollar price averaging" is easy to accomplish through regular, periodic purchases of the shares of any good mutual fund.

If you buy \$500 worth of one stock every month, regardless of the price at which it sells, you will always buy fewer shares when the stock is high and more shares when the stock is low. Thus you will come out with an average cost price which is lower than the average price per share during the period of purchase. You automatically buy more shares when the stock is cheap than when the stock is high; and you do not have to do any guessing about the market.

Mutual Funds

I don't want you to get the idea that I am just a mutual fund salesman taking advantage of a medical convention's hospitality, or that I would recommend mutual funds for everyone. Mutual funds, however, are particularly good things for the small investor who cannot otherwise acquire

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the diversification to permit him to be complacent, and they are ideal things to buy on a dollar averaging program. Most of them provide excellent management, and the cost of this management is rather low. Furthermore, the mutual fund investor is somewhat insulated from the tips and the old wives fables of the folklore purveyors in their stimulation of cupidity.

The Best Portfolios

It has been my observation, over a generation and a half of investment counselling, that the portfolios which are in good stocks, especially growth issues, and are wholesomely neglected, do better than the portfolios of the so called "smart" people who always are trying to trade and make a fast buck.

Health is a great growth industry. You doctors ought to know a great deal about the potentials of new medicines. Leisure is a great growth industry; and since most of the doctors I know treasure their leisure, they should know what the popular and profitable types of leisure are. Natural gas is a great growing industry. The oil industry always grows. Just where some of this Buck Rogers technology in the field of electronics and science is leading us I shudder to think. But it is leading us far, and the electronics industry is sure to expand further.

Indeed, this is a most dynamic economy in a most dynamic age. The race is to the big, to the scientific, to the talented. Many investment adventures of a triumphant and satisfying nature are open to the alert and the prudent, especially to the clients of alert and prudent investment counsellors.

National Foundation Grants Include Several Made in Ohio

The National Foundation has announced several grants in Ohio among those authorized for the year. As previously announced a \$116,400 grant goes to the University of Cincinnati to coordinate and analyze field tests of live virus polio vaccine and to investigate the problems of a number of viruses other than polio.

Western Reserve University gets \$49,325 to continue studies of enteroviruses as possible causes of aseptic meningitis and to investigate certain unusual antibody effects of virus growth.

Another grant of \$75,786 goes to the Western Reserve Poliomyelitis Respiratory and Rehabilitation Center, Cuyahoga County Hospital, for treatment and research.

Named on the new Committee on Professional Education of the Foundation is Dr. John L. Caughey, associate dean and professor of clinical medicine at Western Reserve.

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Medical Care Spending . . .

Study Made by Health Information Foundation Shows That There Has Been a 40 Per Cent Increase Over the Figures for the Year 1929

SPENDING for medical care is now a more important part of the average American family's budget than ever before, Health Information Foundation reported in its official bulletin, *Progress in Health Services*. The Foundation pointed out that spending for hospital care, physicians' services, and other health items last year took 5.3 per cent of the public's consumer-expenditure dollar—a 40 per cent increase over the 1929 figure of 3.7 per cent.

For this stepped-up outlay, however, Americans are receiving a greater quantity and variety of services, as well as vastly improved quality, the report said.

Four Trends

The H. I. F. report singled out four trends that have contributed to the high quality of modern medical care, but at added cost to the consumers:

(1) The average annual number of patient days in general and special hospitals in the United States rose from 0.88 in 1935 to 1.25 in 1956.

(2) During that time the number of births in hospitals increased from just under 800,000 to about 3.8 million a year.

(3) In 1928-31 an annual average of 2.6 out-of-hospital doctor visits was reported by white persons in this country, against a figure of 4.8 in 1957 for the entire population.

(4) During the same period, the proportion of persons seeing a physician at least once a year climbed from 48 to 63 per cent.

All-Time High

For these and other reasons, private spending for medical care is today at an all-time high. The

total outlay last year (not counting government, philanthropic and business expenditures) came to about \$15 billion, five times the total for 1929.

During that time, the Foundation reported, per capita spending for medical care also increased greatly, from about \$24 to \$89. Even when per capita figures are expressed in constant dollars, medical spending has almost doubled—from about \$33 to \$65—since 1929.

Hospital Spending at Top

Some components of medical spending have risen faster than others. Hospital care, which claimed only 13.7 per cent of the consumer health dollar in 1929, last year accounted for a larger share than any other item—25.8 per cent.

Expenditures for physicians' services—which claimed 32.5 per cent of the medical dollar in 1929—took only 24.5 per cent in 1957. The proportion paid for dentists' services also declined, from 16.4 to 11.3 per cent.

Medical care, said the Foundation, "is now becoming a more important part of the American standard of living, while as an 'industry' it is becoming a more important part of the American economy."

Prize Award Paper

District V of The American College of Obstetricians and Gynecologists is offering two \$100.00 awards for the best original investigative or clinical work by residents in the field of obstetrics and/or gynecology.



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Assistants of Ophthalmologists Offered Courses at OSU

The Ohio State University Department of Ophthalmology is offering two short courses, one for office assistants and the other for secretaries of ophthalmologists.

The course in practical perimetry for office assistants will be given July 13, 14 and 15. The course for ophthalmology secretaries, July 16 and 17, both in the Ohio Union, High Street and 13th Avenue, Columbus. The course for office assistants is \$25 and that for secretaries, \$20. Only individuals sponsored by an M. D. are eligible. Registration should be made with William H. Havener, M. D., Acting Chairman, Department of Ophthalmology, University Hospital. Further information may be obtained by writing Dr. Havener.

The course in practical perimetry for office assistants includes the following: July 13—Demonstration of instruments—perimeter, tangent screen, test objects; Chart forms and recording technique—single isopter; multiple isopters; Blind spot description, examination and recording; Scotomas—description, examination, recording; Demonstration and practice recording of scotomata; Introduction of general perimetric principles; Practice in technique under supervision.

July 14: Glaucoma and its perimetric characteristics; Practice measurements and recording of glaucoma fields; Chorioretinitis and its perimetric characteristics; Practice measurements and recording of chorioretinitis fields; Anatomy of the visual pathways; Brain diseases and their perimetric characteristics; Practice measurements and recording of fields in brain disease.

July 15: Hysteria and its perimetric characteristics; Practice measurements and recording of hysterical fields; Harrington screener; The importance of reliability.

The course of ophthalmology secretaries includes the following: Characteristics of a good secretary; Eye anatomy and terminology; Common eye diseases; Visual acuity technique and importance; Community services for the blind; Glaucoma—what the general practitioner should know; Crossed-eyes; The significance of eye symptoms; Lenses and refractive errors; Lensometer technique and practice.

In January more than 50,000 American Cancer Society volunteers began the largest medical statistical study ever undertaken. A million people will be interviewed in door-to-door surveys in the hope of establishing a link between living habits, environment and cancer, which kills 255,000 annually in the United States.

New Members of OSMA

The following are the names of the new members of the Ohio State Medical Association since March 1, 1959. The list shows the county in which they are affiliated, city in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

Cuyahoga County

Joseph C. Amersbach, Cleveland
Robert P. Bolande, Cleveland
Javier Cano, Cleveland
Gerald Goldberg, Cleveland
Joseph H. Rayner, Cleveland
Robert Lee Tannenbaum, Cleveland

Erie County

Bernard B. Huss, Jr., Sandusky

Franklin County

Harvey R. Butt, Jr., Columbus
Rodney B. Hurl, Columbus
Robert W. Secrest, Columbus

Hamilton County

Burton A. Russman, Cincinnati

Hancock County

James Best, Findlay

Lucas County

Robert Hendricks, Toledo
John R. Yoder, Toledo

Mahoning County

William D. Loeser, Youngstown
Albert M. Starr, Youngstown

Monroe County

Hartmut T. Weber, Woodsfield

Putnam County

John R. Brown, Ottawa

Stark County

George B. Zaboji, Canton

Summit County

Charles A. East, Akron
Frederick T. Fiedorek, Cuyahoga Falls
Donald W. Martin, Cuyahoga Falls
Robert A. McDougal, Akron
Roman A. Wojanowski, Akron

Van Wert County

Joseph R. Kreischer, Convoy
Ralph E. Rasor, Jr., Van Wert

Washington County

Amos V. Smith, Jr., Marietta

Wayne County

Gerhard Berner, Wooster
Roland Burelli, Rittman

Professor Joseph B. Homan, 65, pioneer in medical art and for 40 years director of the Department of Medical Art in the University of Cincinnati College of Medicine, died on March 17. His widow survives.

Radiology Reporter is the name of a publication distributed by Winthrop Laboratories and summarizing interesting and significant data presented at meetings of radiology societies.



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- more than half of the cases involved hypertension of at least 6 years' standing, with many histories of up to 20 years' duration

THE SIDE-EFFECTS PROBLEM WAS MINIMIZED IN MOST PATIENTS:

Chart shows gratifyingly low incidence of side effects in 233 patients given Singoserp with no other antihypertensive medication

Side Effect	Number	Per Cent
Lethargy	7	2.9
Headache	6	2.5
Gastrointestinal upset	3	1.2
Vertigo	2	0.8
Nasal congestion	1	0.4

DOSAGE: Initially, 1 to 2 tablets (1 to 2 mg.) daily.
SUPPLIED: Singoserp Tablets, 1 mg. (white, scored); bottles of 100.
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In Memoriam . . .

Adam Paul Basinger, M. D., Terrace Park; Eclectic Medical College, Cincinnati, 1908; aged 77; died March 6; member of the Ohio State Medical Association and the American Medical Association. Dr. Basinger began his practice at Pleasant Plain, three years later moved to Blanchester and for the past 23 years has been practicing in Terrace Park. He was a member of the Masonic Lodge, the Kiwanis Club, the Junior Order of United American Mechanics and the Presbyterian Church. For several years he has sponsored a summer camp for children at Pleasant Plain. Surviving are his widow, a son, two daughters and two sisters.

Charles A. Crane, M. D., Canton; Jefferson Medical College of Philadelphia, 1897; aged 84; died March 21; former member of the Ohio State Medical Association. Dr. Crane opened his practice in Canton after completing special studies in eye work in Pennsylvania. He retired in 1954 after completing 55 years of practice. Among affiliations were memberships in several Masonic bodies. His widow survives.

Joseph G. Eckstein, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1900; aged 86; died March 11. Dr. Eckstein practiced for most of his life in the West End area of Cincinnati.

John E. Gamble, M. D., Steubenville; Ohio State University College of Medicine, 1920; aged 67; died March 12; member of the Ohio State Medical Association and the American Medical Association. Dr. Gamble practiced medicine for almost 40 years in Steubenville. He was a member of the United Presbyterian Church and several Masonic bodies. Surviving are his widow, two sisters and a brother, Dr. Marion D. Gamble, of New Holland.

Arthur E. Gillette, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1893; aged 90; died March 16; former member of the Ohio State Medical Association. A resident of Cincinnati for all of his professional career, Dr. Gillette went into semi-retirement about 10 years ago. He was a member of the Masonic Lodge and the Federated Church. Survivors include three sons and three daughters.

John B. Grothaus, M. D., Hamilton; Medical College of Ohio, Cincinnati, 1894; aged 91; died March 8; member of the Ohio State Medical Association and the American Medical Association. Dr. Grothaus practiced for more than 50 years in Hamilton and Butler Counties. Active in a number of organizations, he was a member of several Masonic bodies, the Knights of Pythias, the Presbyterian Church and the Grange. Survivors include a daughter and three brothers.

James M. Harsha, M. D., Lake City, Fla.; Ohio State University College of Medicine, 1926; aged 63; died March 10. Dr. Harsha practiced medicine for 15 years in Washington Court House prior to World War II. He entered the Army Medical Corps early in the war and attained the rank of colonel. Following the war, he joined the staff of the Veterans Administration Hospital at Miami, Florida, and later transferred to the VA Hospital at Lake City, Fla. His widow and two daughters survive.

Mortimer Herzberg, Jr., M. D., Hillsboro; University of Cincinnati College of Medicine, 1939; aged 47; died March 17 of a self-inflicted wound; former member of the Ohio State Medical Association and the American Medical Association. During World War II, Dr. Herzberg served with the Army Medical Corps in the Pacific

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Theater. He set up practice in New Richmond in 1946 and the following year moved to Hillsboro. Dr. Herzberg in 1951 was shot by a crazed man to whom he had refused narcotics. Paralyzed from the waist down, he eventually re-established practice in Hillsboro. He had been in the Veterans Administration hospital since last December. Survivors include his widow and two children.

Samuel Hindman, M.D., Columbus; Ohio State University College of Medicine, 1910; aged 79; died April 6; member of the Ohio State Medical Association and the American Medical Association. Dr. Hindman was in private practice in Columbus until World War I when he went into the Army Medical Corps. After the war he accepted an appointment with the Veterans Administration and had served at VA hospitals principally in Cleveland and Columbus. Surviving are his widow and a daughter, Dr. Sarah M. Hindman (Mrs. A. F. Pitcher) of Bethlehem, Pa.

Fred J. Hunter, M.D., Gulfport, Fla.; Starling Medical College, Columbus, 1902; aged 85; died March 17; former member of the Ohio State Medical Association. Dr. Hunter practiced for 20 years in Clyde. He then moved to Marion where he practiced until his retirement in 1948. Survivors include his widow and a son, Dr. Fred J. Hunter, Jr., of New York City; also two sisters.

Walter A. Jaquith, M.D., Columbus; Queen's University Faculty of Medicine, Canada, 1898; aged 84; died April 2. Dr. Jaquith was living in retirement following a number of years as medical director of the Columbus Mutual Insurance Company. He formerly held a similar post with the Prudential Insurance Company of Newark, New Jersey. His widow and a son survive.

Harry Kusmin, M.D., Cleveland; University of Pittsburgh School of Medicine, 1912; aged 72; died March 23; former member of the Ohio State Medical Association. Dr. Kusmin practiced medicine for 30 years in Cleveland. Affiliations included membership in several Masonic bodies. Surviving are his widow and two daughters.

Frank A. LaCamera, M.D., Warren; University of Cincinnati College of Medicine, 1921; aged 65; died March 23; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. LaCamera practiced medicine for 37 years in Warren and for many years was physician also for the Trumbull Lamp Division of General Electric. He was vice-president of the Warren Civic Music Association and was known as a field trial judge and authority on dogs. A veteran of World War I and member of the

Methodist Church, he is survived by his widow and two sons, Dr. Frank LaCamera, Jr., of Cleveland, and Dr. Robert LaCamera, of Hamden, Conn.

Middleton H. Lambright, Sr., M.D., Cleveland; Meharry Medical College, 1898; aged 94; died March 21. A practicing physician in the Woodland Avenue neighborhood since 1923, Dr. Lambright moved to Ohio from Kansas City. A member of the Baptist Church, he is survived by a daughter and his son, Dr. Middleton H. Lambright, Jr., with whom he was associated in practice.

Frederick J. Livingston, M.D., Macedonia; University of Toronto Faculty of Medicine, 1913; aged 69; died March 19; member of the Ohio State Medical Association, the American Medical Association and the American Psychiatric Association. A Canadian by birth, Dr. Livingston moved to Cleveland in 1922 and engaged in private practice until 1937 when he joined the staff of the Hawthornden State Hospital. During World War I, Dr. Livingston served with the Royal Canadian Medical Corps. Surviving are his widow, two daughters, two brothers and a sister.

Harvey G. McCandless, M.D., Cincinnati; University of Cincinnati College of Medicine, 1933; aged 51; died April 5; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. A practicing physician at Ft. Thomas, Kentucky, for many years, Dr. McCandless moved to Cincinnati in 1948. During World War II he served in the Army Medical Corps with the rank of major. Affiliations included memberships in the American Urological Society, the Ohio Historical and Philosophical Society, and the Christian Church. Surviving are his widow, two children, his mother and a sister.

Norman B. Osborne, M.D., Andover; Hahne-mann Medical College and Hospital of Philadelphia, 1908; aged 74; died April 2; former member of the Ohio State Medical Association. A practicing physician over a half century, Dr. Osborne recently was honored by the Ashtabula County Medical Society when he was presented the 50-Year Award of the OSMA. He was a member of the Methodist Church, the Masonic Lodge and the American Legion. Surviving are his widow, a brother and a sister.

Alfred H. Potter, M.D., Springfield; Ohio State University College of Medicine, 1909; aged 76; died April 3; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. Dr. Potter was a third generation physician in

Springfield, his grandfather and father having practiced there before him. He was a veteran member of the Board of Trustees of Springfield City Hospital. A veteran of World War I, he was a member of the Springfield Country Club, the Van Dyke Club, the Polo Club, the Presbyterian Church and several Masonic bodies. Surviving are his widow and three sisters.

Cassius M. Shepard, M. D., Columbus; Jefferson Medical College of Philadelphia, 1899; aged 86; died March 24; member of the Ohio State Medical Association, the American Medical Association and the American Academy of Orthopaedic Surgeons; Fellow of the American College of Surgeons. Dr. Shepard was living in retirement after practicing orthopedic surgery for many years in Columbus.

Gordon T. Wagner, M. D., West Richfield; Western Reserve University School of Medicine, 1939; aged 46; died April 5 in a traffic accident; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. After World War II, during which he served as captain in the Army Medical Corps, Dr. Wagner opened an office in Hinckley. A few years later he moved to West Richfield. A member of the Methodist Church, he is survived by his widow, four sons and his parents.

Harley E. Ward, M. D., Pemberville; Physio-Medical College of Indiana, Indianapolis, 1902; aged 84; died March 21; member of the Ohio State Medical Association and the American Medical Association; recipient of the OSMA 50-Year Award. Dr. Ward practiced a total of 57 years, 45 of those years in and around Pemberville. Active in community affairs, he was past-president of the local Board of Education and for many years director of the local high school band; also a member of the Presbyterian Church. Surviving are a daughter and two sons, one of whom is Dr. David Paul Ward, of Pleasant Plains; also two brothers.

Fort Steuben Academy

The Fort Steuben Academy of Medicine and the Committee on Trauma of the American College of Surgeons presented the Annual Trauma Symposium on April 14 in Steubenville. Principal speaker was Dr. George J. Curry, chairman of the Regional Committees, American College of Surgeons, and chief consultant in surgery of trauma, Hurley Hospital, Flint, Mich. His topic was "Special Problems in Surgical Treatment of Trauma and Management of Lower Extremity Injuries." Opening discussion was Dr. John O. Rankin, surgical staff, Ohio Valley General Hospital, Wheeling Clinic, Wheeling, W. Va.



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Activities of County Societies . . .

First District

(COUNCILOR: CHARLES W. HOYT, M. D.,
CINCINNATI)

CLERMONT

Dr. Charles Simmons, of Bethel, was host to the Clermont County Medical Society and the Clermont County Tuberculosis and Health Association for a meeting on March 25 at the D-X Ranch. Speaker was Dr. Robert H. Browning, director of the Ohio Tuberculosis Hospital, Columbus, who discussed phases of the "whole man" treatment and rehabilitation of the tuberculous patient.

CLINTON

The annual "Doctor's Day" observed March 4 by the Clinton County Medical Society featured a talk and film, "Man in Space," presented by Major Arthur E. Ryan, of the U. S. Air Force medical corps.

The meeting was held at the new home of Dr. and Mrs. Robert Cronebaugh, Blanchester, and the wives observed the tradition of presenting the doctors with red chrysanthemums in recognition of their service to the community. — *Wilmington News Journal*.

HAMILTON

The Academy of Medicine of Cincinnati met on March 3. Speaker was Mr. Robert Laurer, who discussed "The Science of Financial Independence."

On April 7 a symposium was conducted on the subject, "Steroid Therapy and Its Newer Concepts." Speakers were Dr. Elmer Alpert, director of clinical research, Merck & Company, West Point, Pa., and Dr. L. Maxwell Lockie, attending physician, Buffalo General Hospital, Buffalo, N. Y.

Specialty groups which met during March include the following: Medical Women's Club of Cincinnati; Cincinnati Society of Neurology and Psychiatry; Cincinnati Surgical Society; Cincinnati Ophthalmologic Society; Cincinnati Oto-Laryngological Society; Cincinnati Society of Anesthesiologists; Cincinnati Obstetrical and Gynecological Society; Cincinnati Orthopaedic Club; Cincinnati Society of Internal Medicine; Cincinnati Dermatological Society; Radiological Society of Greater Cincinnati; Cincinnati Surgical Society.

Mr. Edward F. Willenborg, executive secretary of the Academy of Medicine of Cincinnati, has been appointed general counsel for the Academy in addition to his other duties.

Second District

(COUNCILOR: R. DEAN DOOLEY, M. D., DAYTON)

CLARK

Dr. Ivan F. Duff, associate professor of internal medicine at the University of Michigan, was guest

speaker at the March 16 meeting of the Clark County Medical Society in Springfield. His topic was "Anticoagulants."

DARKE

"Mental Health," was the topic discussed at the March 17 dinner meeting of the Darke County Medical Society at the Treaty City White Shrine Temple, Greenville. Speaker was Dr. D. A. Thomas, Miami Valley Guidance Center, Piqua.

MIAMI

Dr. James E. Watson, Columbus, was guest speaker at the March 6 meeting of the Miami County Medical Society in the Dettmer Hospital. "Obstetrics Anesthesia" was discussed.

Third District

(COUNCILOR: FLOYD M. ELLIOTT, M. D., ADA)

ALLEN

A dinner meeting of the Lima and Allen County Academy of Medicine was held at the Shawnee Country Club, Lima, on March 10. Speaker was Dr. Ernest W. Johnson, associated with the rehabilitation service at University Hospital, Columbus. His talk was on the problems of rehabilitation. The *Lima News* published a three-column picture of the speaker, Dr. T. D. Allison, Society secretary, and Dr. H. C. Kingsbery, program chairman.

HARDIN

Dr. Howard Sirak of Columbus was guest speaker March 10 at a dinner meeting of the Hardin County Medical Society held at Hardin Memorial Hospital.

Dr. Sirak, who is chief of the Division of Cardio-Vascular Surgery of Ohio State University's School of Medicine, spoke on "Recent Advances of Heart Surgery."

The speaker was introduced by Dr. J. C. Lindsey, program chairman for the month.—*Kenton Times*.

MARION

William J. McAuliffe, Jr., a member of the legal staff of the American Medical Association, was principal speaker at a joint meeting of the Marion County Academy of Medicine and the Marion County Bar Association on April 7 at the Hotel Harding, Marion. His topic was "Medico-Legal Relationships."

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

LUCAS

The Inter-Hospital Postgraduate Lecture Series, presented by the Medical Advancement Trust of

(Continued on Page 716)

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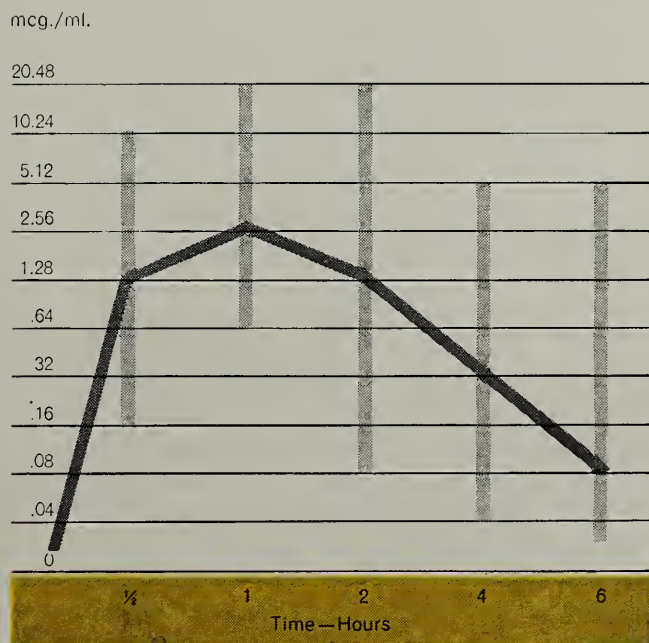
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Range of blood levels obtained from one dose of 400 mg. ERYTHROCIN SUSPENSION. Medication was administered to 30 volunteer adults, and represents a dosage of approximately 6 mg./Kg. Bars show ranges—continuous line indicates medians.



the Maumee Valley Hospital, is scheduled Wednesday and Thursday, May 6 and 7. Held in cooperation with the Academy of Medicine of Toledo, the lectures will be held at the Academy Building, 3101 Collingwood Blvd., Toledo.

Speaker will be Dr. S. Leon Israel, professor of gynecology and obstetrics, Graduate School of Medicine, University of Pennsylvania, Philadelphia.

"Endocrine Problems of Clinical Significance—Modern Concepts," is the theme. Lectures are as follows: Wednesday—12 noon, "Differential Diagnosis of Amenorrhea"; 4:30 p. m., "Menstrual Disorders of Adolescence"; 8:15 p. m., "Ovulation."

Thursday, May 7—12 noon—"Dysfunctional Uterine Bleeding, Including Treatment of Menopause"; 4:30 p. m., "Practical Gynecologic Hormone Therapy"; 8:15 p. m., "Practical Gynecologic Hormone Therapy, (concluded)."

PUTNAM

February meeting of Putnam Society was held at Ottawa, February 3. Guest speaker was Dr. Paul F. Orr, Councilor for Fourth District.

Dr. Orr discussed the current socio-economic problems in the United States and their relation to the practice of medicine. He also reviewed some of the actions of the House of Delegates meeting in Minneapolis last December.

Also discussed was the meeting of the County Medical Society officers in Columbus February 22 and the scheduled annual meeting of the Ohio State Medical Association in Columbus. — H. N. Trumbull, M. D., Correspondent.

Fifth District

(COUNCILOR: GEORGE W. PETZNICK, M. D., CLEVELAND)

ASHTABULA

Dr. Norman B. Osborne, Andover, recently was presented the 50-Year Award of the Ohio State Medical Association by officers of the Ash-tabula County Medical Association. Presentation was made at the Brown Memorial Hospital where Dr. Osborne was a patient at the time.

CUYAHOGA

"Blood Transfusion — When? Why? Why Not?" was the theme of the afternoon program of the Academy of Medicine of Cleveland on March 29. Those who spoke and their subjects were: Dr. Edward E. Siegler, "The Problems of the Single Blood Transfusion"; Dr. John H. Davis, Jr., "A Surgeon's View of Blood Transfusion"; Dr. Robert D. Mercer, "Some Special Problems Associated with Blood Transfusion in Infants and Children"; Dr. Oscar D. Ratnoff, "The

Use of Blood and Blood Fractions in Management of Patients with Disorders of Blood Coagulation."

A panel discussion followed with the foregoing speakers and the speaker of the evening as panelists and Dr. Russell Weisman, Jr., as moderator.

The speaker of the evening was Dr. Louis K. Diamond, associate professor of pediatrics, Harvard Medical School and director of the Hematology Laboratory, Blood Bank and Blood Grouping Laboratory, Children's Medical Center, Boston. His subject was "Clinical Application of Knowledge of Human Blood Groups."

The April 17 meeting of the Academy was co-sponsored by the Professional Section of the Diabetes Association of Greater Cleveland. The program included the following speakers and subjects:

"Evaluation of Chlorpropamide (Diabinese) in the Treatment of Diabetes Mellitus," Dr. O. P. Schumacher.

"The Use of DBI (Phenformin) in Childhood Diabetes," Dr. William B. Weil, Jr.

"Experience with DBI in Adult Patients with Diabetes Mellitus," Dr. James W. Craig.

A panel discussion followed with the foregoing speakers and the speaker of the evening with Dr. Max Miller as moderator.

Speaker of the evening was Dr. Rachmiel Levine, chairman of the Department of Medicine, Michael Reese Hospital, Chicago, whose topic was "A Critical Evaluation of the Oral Hypoglycemic Drugs."

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

STARK

Members of the Stark County Medical Society heard an address by Dr. H. William Clatworthy, Jr., chief of surgical service at Children's Hospital, Columbus, on March 12. His topic was "Infant Surgery."

A joint meeting of the Stark County Medical Society and the Stark County Bar Association was held in Canton's Mergus Restaurant on March 25. Attorney Robert Hillbish, chairman of the joint committee on inter-professional relationship for the two groups, presented Dr. Samuel R. Gerber, Cuyahoga County coroner, whose discussion was in the medico-legal fields common to both doctors and lawyers.

COLUMBIANA

Dr. Fiorando Simeone, professor of surgery at Lakeside Hospital in Cleveland, was the guest speaker when the Columbiana County Medical Society met March 17 at the Wick Hotel in Lisbon.

Dr. Simeone gave a comprehensive discussion on varicose veins and chronic leg ulcers.

During the business meeting conducted by president Dr. William Kolozsi, the Society decided to lend financial support to the health tent at this year's Columbiana County Fair in August.

A committee was appointed to revamp the constitution of the society. The group also gave consideration to accept certain non-medical members into the Society as honorary or associate members. These would be key people in the county such as social workers and others interested in the public welfare.—*Salem News*.

BELMONT

"Diagnosis by Means of Roentgenology" was the subject discussed at the March 19 dinner meeting of the Belmont County Medical Society at the Belmont Hills Country Club with the Auxiliary. Speaker was Dr. Paul A. Jones, Zanesville.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

SCIOTO

Wayne J. Graf, vice-president and trust officer of the Ohio National Bank at Columbus, spoke March 9 at a meeting of the Scioto County Medical Society in the nurses' home of Portsmouth General Hospital. Mr. Graf spoke on "Intelligent Planning of a Doctor's Estate." Dr. Samuel L. Meltzer arranged the program. A buffet supper was served.

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILlicothe)

FRANKLIN

The Bulletin of the Columbus Academy of Medicine reports outstanding work done by physicians during the January floods in the Columbus area. Between 8,000 and 9,000 people in the Columbus-Franklin County area were directly affected by the flood. Approximately 1,000 people were evacuated and cared for without a loss of life.

In spite of the fact that the 1959 flood was not a major medical disaster, 35 physicians of the Columbus Academy, 89 nurses, 12 hospital administrators, 1 dentist and several pharmacists took an active part in the medical care of disaster victims. Many spent hours and days away from offices and other duties.

MADISON

Madison County's proposed hospital will be operating at capacity within a short time from the completion date, according to expectations expressed by Mrs. Francis Helmick, administrator of Union County Memorial Hospital, as she addressed the Madison County Medical Society for the February meeting. She told the group that at

the present time Union County's hospital is operating at 110 per cent of capacity and that the obvious need in the Madison County area is very similar to Union.

At the March meeting, members heard further discussion of the local proposed hospital's progress. Dr. W. T. Bacon, president, reported on progress to date in preliminary planning for the Madison County Hospital.

Dr. Paul Wolber, secretary, reported on current state and national legislative activity pertaining to medicine and public health, and also reviewed recent developments in the field of new drugs and therapeutics.

Dr. Sol Maggied, society delegate, reviewed resolutions scheduled to be presented at the OSMA Annual Meeting.

UNION

Dr. E. J. Marsh, of Broadway, was honored at a banquet of the Union County Medical Society on March 12 in Marysville, when he was presented the 50-Year Award of the Ohio State Medical Association.

A native of Portsmouth and graduate of the former Starling-Loving Medical College in Columbus, Dr. Marsh has practiced in the Union County community of Broadway for 40 years. He began his practice in Nelsonville and from 1909 to 1918 practiced in Waldo.

Central Ohio Heart Association Program Scheduled May 7

Arthur C. Guyton, M. D., noted author, investigator, teacher and lecturer, will be the principal speaker at the combined annual meeting and Scientific Council session of the Central Ohio Heart Association, May 7, at the Neil House in Columbus.

A professor of physiology and biophysics, he is also chairman of the department at the University of Mississippi School of Medicine, Jackson, Miss.

Dr. Guyton will deliver two addresses during the day. At the annual meeting luncheon, he will discuss "The Value of Cardiovascular Research to Mankind." Before members of the Scientific Council, he will speak on "The Venous Circulation: Its Role In Regulation of Cardiac Output and Arterial Pressure."

At the Scientific Council session, which is scheduled to convene at 3:00 P. M., Dr. Guyton will join R. W. Kissane, M. D., Columbus, and Robert H. Schoene, M. D., Columbus, in a panel discussion on "Common Cardiovascular Problems." Robert C. Kirk, M. D., Columbus, will be the moderator.

The author of some 90 printed works, Dr. Guy-

(Continued on Page 721)

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ton's most recent book titled, *Function of the Human Body*, was published earlier this year. He is also the author of the widely-accepted *Textbook of Medical Physiology* published in 1956.

A past-president of the Mississippi Heart Association, he is currently a member of the board of directors of the American Heart Association.

Following Dr. Guyton's address, the COHA Scientific Council will conduct a business meeting and elect officers for the coming year.

Ready Reserve Not Under Selective Service Control

The following letter from Gen. Lewis B. Hershey, Director, Selective Service System, appeared in the March 23 *AMA News*:

"I wish to call your attention to an article which appeared in *The American Medical Association News* of February 9, relative to the transfer of the Ready Reserve of the staffs of hospitals and medical schools to the Standby Reserve.

"The Armed Forces Reserve Act, as amended in 1955, does not provide for participation of the National Advisory Committee to the Selective Service System either in the Ready Reserve or the Standby Reserve programs in an advisory capacity.

"The Ready Reserve program is a matter under the Department of Defense and the Secretaries of the Army, Navy, and Air Force. The transfer of a reservist to the Standby Reserve is, therefore, a determination to be made by the Armed Force of which the Reserve officer is a member and not of the Selective Service System. The Selective Service System has not and does not issue any directives with regard to the Ready Reserve as it applies to transfer to the Standby Reserve since it is not a matter under the authority of this agency. The information published in your *AMA News* was erroneously attributed to the Selective Service System and deserves immediate correction.

"The Director of the Selective Service System is charged by the Reserve Act of 1952, as amended, with the administration of the Standby Reserve program and no provision in the Act provides for an availability determination by the National Advisory Committee."

Contributions Held Legal

The Ohio Supreme Court has decided that Ohio corporations may lawfully contribute to a committee advocating the adoption of a Constitutional amendment, tax levy or bond issue. This decision overruled the Cuyahoga County Court of Appeals in the case of *State of Ohio ex rel John T. Corrigan v. The Cleveland-Cliffs Iron Company*.

Cook County Graduate School of Medicine

INTENSIVE POSTGRADUATE COURSES

STARTING DATES — SUMMER, 1959

SURGERY—Surgical Technic, two weeks, June 1, June 15. Surgery of the Colon & Rectum, one week, June 1. Gallbladder Surgery, three days, June 1. Surgery of Hernia, three days, June 4. General Surgery, one week, June 15. Blood Vessel Surgery, one week, June 22. Femoral Arteriography, 4 days, June 9. Pediatric Surgery, one week, June 1. Fractures & Traumatic Surgery, two weeks, June 15.

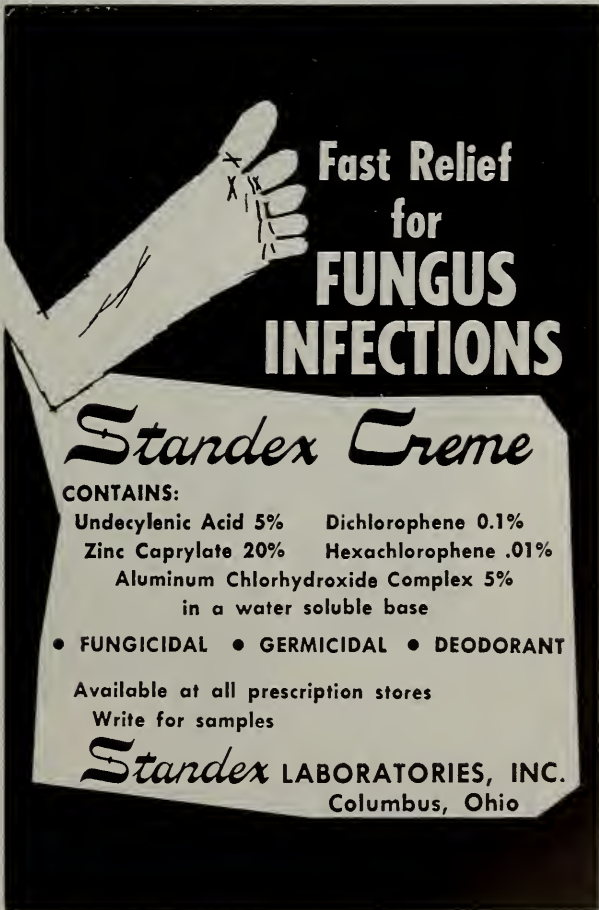
GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, June 15. Vaginal Approach to Pelvic Surgery, one week, June 8.

MEDICINE—Board of Internal Medicine Review Course (For Part I Applicants), one week, Sept. 14. Advanced Electrocardiography, one week, June 22. Gastroscopy & Gastroenterology, two weeks, Sept. 14.

RADIOLOGY—Diagnostic X-Ray two weeks, June 15. Clinical Uses of Radioisotopes, two weeks, Sept. 21.

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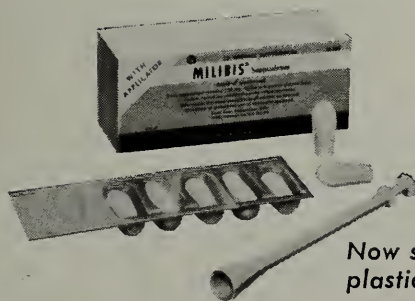
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Activities of Woman's Auxiliary . . .

CHAIRMAN PUBLICITY COMMITTEE—Mrs. W. J. Horger,
1100 Ohio Ave., East Liverpool, Ohio
(See Page 610 for roster of officers.)

COLUMBIANA

The meeting of the Columbiana County Medical Auxiliary was held March 16 at the Masonic Temple in Lisbon. Mrs. Fred Jose, Mrs. Peter Cibula and Mrs. Chester DeWalt were named to the nominating committee.

Mrs. Carl Lehwald presented a program on civil defense and gave pamphlets to the members elaborating on the subject. A White Elephant sale was held; the proceeds to be given to the AMEF.

ERIE

The Woman's Auxiliary to the Erie County Medical Society met March 1 at the Business Women's Club for dessert.

Reports were given on the successful Valentine teas, given at Good Samaritan and Providence Hospitals for hospital personnel, in which members named delegate to the Ohio State Medical Convention.

Mrs. Edward Gillette, auxiliary member, was the program speaker. Her title, "My Uncle's Icebox," gave a very interesting experience of living in Anchorage, Alaska, for two years. This she shared with her husband, Dr. Gillette, and their children. Her talk was illustrated with colored slides.

FRANKLIN

The Woman's Auxiliary to the Columbus Academy of Medicine has had an eventful year under the leadership of Mrs. George O. Kress.

Dr. Robert M. Inglis, President of the Academy, met with the members of the Executive Board at their first meeting in September.

In October, a luncheon meeting was held at St. Stephen's Episcopal Church and a tour of this beautiful church was enjoyed. A most enlightening talk on "The Dangers of Self Medication" was given by Dean Lloyd M. Parks, of the College of Pharmacy.

"Hello Out There," a one-act play by Wm. Saroyan, was presented by members of the Columbus Community Theater at the November meeting.

The annual December Dinner-Dance was given by the Academy, held at Ilonka's.

The Jan. 19 meeting was a most informative one. The panel discussion, "Academy Research on Fund Drives," was presented in an open meeting. Dr. Robert Inglis was the moderator. The panel included Dr. James Patterson of the Academy of Medical Service Committee; Gerald C.

Fry, Executive Director of the Franklin County Tuberculosis Society; John C. Elam, Columbus attorney, and Edward Lentz, Executive Secretary of the Metropolitan Health Committee of United Appeals.

At the February dinner meeting, which was held at the Grandview Inn, officers for 1959-60 were elected. They are: Pres., Mrs. Arthur James; Pres.-elect., Mrs. Norris Lenahan; V.-Pres., Mrs. H. I. Humphrey; Rec. Sec., Mrs. Nicholas Michael; Corresponding Sec., Mrs. Maurice Zox; Treas., Mrs. Richard Wehr, and Ass't. Treas., Mrs. Jonathan Busby.

On March 16 a Guest Luncheon and Fashion Show was held at the Youth Center on the Ohio State Fairgrounds. Invitations were sent by our Auxiliary to the wives of the members of the Central Ohio Academy of Pharmacy, the Columbus Dental Society and the Columbus Academy of Veterinary Medicine. "Travel in Style" was the theme of the show. Special styles from New York were shown by the House of Fashion, Columbus, and modeled by Auxiliary members. This benefit luncheon helped bring Juno, the Plastic Lady, to Columbus for the Academy Health Fair.

More than 100 Auxiliary members conducted tours during the Health Fair from 9:00 A. M. to 3:00 P. M. on Tuesday, Wednesday, Thursday, and Good Friday for 12,000 eighth graders. Several hundred Auxiliary members worked tirelessly assisting the Academy members during this unique project in Public Health Education.

New officers will be installed at the May luncheon meeting which will be held at the Desert Inn. The program for the afternoon "Wahins in Oahu," Women in Hawaii, is being arranged by Mrs. Nicholas Michael and Mrs. James Williams.

HAMILTON

The March 17 meeting of the Auxiliary to the Hamilton County Medical Society was held at the Hyde Park Country Club.

Following luncheon, Dr. John Millette, President of Miami University, was introduced by Mrs. Vinton E. Siler, and spoke on "Education for Tomorrow."

The business meeting was presided over by Mrs. Earl C. Van Horn, president. Mrs. Carl Schilling, chairman of the Future Nurse Club Committee, reported that "Careers Day" was a great success. Held on February 12, it was participated in by over 200 girls from 15 high schools in Greater Cincinnati. Twelve careers were represented. The girls observed actual on-the-job procedures. Lunch-



To the relief of musculoskeletal pain, new **MEDAPRIN*** adds restoration of function

Analgesics offer temporary relief of musculoskeletal pain, but they merely *mask* pain rather than getting at its *cause*. New Medaprin, in addition to bringing about prompt subjective improvement, promotes the *restoration of normal function* by suppressing the inflammation that *causes* the pain.

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eon was served to them by the various hospital auxiliaries and an hour of evaluation followed.

LUCAS

The following information includes some of the highlights of events which have been sponsored by the Woman's Auxiliary of Lucas County.

On February 25 Mrs. Dick Baer, chairman of the Para-Medical (Nurse Recruitment) Group, and 175 members of the Future Nurse Clubs in local high schools toured Children's Hospital. Mrs. Baer and her committee now have 14 high schools represented at the monthly meetings.

On March 10 the Auxiliary held its annual Invitational Dessert. Each woman's organization in Toledo was invited to send a representative. The speaker for the day was Mr. Dudley Craft Watson, well-known lecturer from the Art Institute of Chicago. His talk illustrated with movies revolved around the trips he has made to Russia. At this same meeting, a bake sale was held under the co-chairmanship of Mrs. John Dickie and Mrs. C. J. A. Paule, from which \$180.00 was made.

Several study groups have proven to be outstanding. The group titled "Psychology" has had as its leader, Dr. Doris Berlin. Members have discussed many subjects which include "Slips of the Tongue," "Every Day Problems of Being a Doctor's Wife," "Teen Age Problems," and the "Psychology of Clothes." Mrs. Fred Hawkins is the co-chairman.

"Travel With Friends" study group has been an energetic group under the chairmanship of Mrs. Paule. Each month certain countries have been selected and the members of the group do research into the history, geography, cuisine and present day problems of each country. Members who have visited the countries show their colored slides or movies and a luncheon of native foods is prepared.

The Annual Essay contest sponsored by the AMA was a success in the local area. Mrs. Todd, chairman of the local contest, announced that the three winners in the area are: Dexter Snyder, Divilbiss High School senior; Lucy Sawyer, Notre Dame Academy junior, and Kenneth Alexander, Whitmer High School junior.

The final Fund Raising Project was a benefit bridge luncheon, under Mrs. Henry Cool. It was held April 7 in the Academy of Medicine Building.

MAHONING

The Woman's Auxiliary to the Mahoning County Medical Society held the annual tea for prospective nurses March 12 at the South Side Hospital Nurses' Home. Over 200 Junior and Senior high school students, scholastically qualified

to enter the nursing profession, were present to tour the hospital.

The Auxiliary annually offers one scholarship each to Youngstown Hospital and St. Elizabeth Hospital school of nursing. Miss Virginia Markulin and Miss Dorothy Pearson, who are now in training on Auxiliary scholarships, poured at the tea.

MONTGOMERY

During the last two weeks in February and the first week in March the Montgomery County Woman's Auxiliary distributed 80,000 Health Wallet cards to Public Health services, personnel of five different hospitals, University students and faculty, high school seniors and faculties, Auto Club, travel agencies, large industries, small businesses, PTA groups, garden clubs and women's groups. The two Dayton newspapers published seven different articles about the Health Wallet card and two pictures.

Two of the most successful programs were on Health. The first one in October was called "Progress with the Retarded Child in the Community" and consisted of four panel members, one the head of Special Education of the Board of Education, another, the assistant director of the Child Guidance Center and a psychiatrist, the third, a child psychologist and director of Valley Day School for Retarded Children, and the fourth speaker, Director of Council for Retarded Children of Montgomery County. The Auxiliary also permitted the Sheltered Workshop to display its work of which \$60,000 worth was bought by members and guests. The Dental Auxiliary and the Pharmacists' Auxiliary were guests.

The other meeting on health was the March program called "Hypnosis in Modern Medicine." A panel consisted of two psychiatrists, one internist and one obstetrician who each explained how he used hypnosis in his practice. The newspapers sent reporters to cover the meeting and there were two articles in the press.

SCIOTO

Along with its nurse recruitment program, the Woman's Auxiliary of Scioto County Medical Society is expanding its interest and is seeking to recruit young people in other paramedical careers in the health and medical fields.

Included in the paramedical category are medical technologists, x-ray technicians, physiotherapists, occupational therapists, speech therapists, medical librarians, and medical social workers, as well as nurses.

To benefit the nurse recruitment and new paramedical career recruitment, the Scioto County Medical Auxiliary held its fifth annual luncheon



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and style show in the auditorium of the Elk's City Club.

Mrs. Miller F. Toombs was general chairman of the luncheon style show project with Mrs. Spencer Miller as co-chairman.

SUMMIT

The Woman's Auxiliary to the Summit County Medical Society met for luncheon at the Fairlawn Country Club on April 7. Mrs. Thelma Dirham, owner and operator of the Basket Shop, Medina, spoke on "The Human Heart and Home." A business meeting followed the program.

"Health Days" sponsored by the Woman's Auxiliary to the Summit County Medical Society in O'Neil's Auditorium, March 6, 7, and 9 was attended by approximately 8,000 persons, who braved the blizzard-like weather to see the many exhibits. There were 39 exhibits this year, each one using a newer, fresher, and more enthusiastic approach.

The Akron Jaycees had a trailer set up across from O'Neil's in which they displayed driver training equipment and urged passers-by to attend Health Days.

Among the more popular exhibitors was the Society for Crippled Children who held actual classes in the auditorium. Akron Dairy Council had a nutrition experiment with mice, conducted by school children in the area. Three schools displayed their mice. The Chamber of Commerce exhibit of traffic accident pictures appealed to the teen-agers and had a sobering effect on all who viewed them.

Approximately 1500 persons received chest x-rays and many stood in line for blood pressure readings and dental examinations. The diabetic kits were very popular again this year.

Health days this year has been evaluated as being the best ever.

TRUMBULL

The members of Trumbull County Auxiliary met for dessert March 19 at the Trumbull Memorial Hospital student nurses' lounge. Student nurses were their guests. Members brought books and records for the student nurses' lounge and recreation room.

During the business meeting a report was made that a total of \$271 had been raised for the AMEF. The members were asked to take their used magazines to the Mental Health chairman, Mrs. J. Schlect, to be used by patients at Woodside Receiving Hospital in Youngstown. Mrs. Bruce Brown, chairman of the Ways and Means Committee, announced the date of this year's Gardenia Ball.

Miss Lee, a representative from the Rappold Co., gave a talk on "Accessories."



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Why Glasses. Danger Ahead—Glaucoma. Check Your Child's Eyes. Three more leaflets in a series by the Prevention of Blindness Department, Philadelphia Association for the Blind, Inc. Write the Association, 100 East Price Street, Philadelphia 44, Pennsylvania.

* * *

Facts about Color Coding. Explains color coding of hospital products to save time and labor, and to add safety, in their handling. Write Becton, Dickinson and Company, Rutherford, N. J.

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Your Gifted Child. Helps parents guide their gifted child in his development and to have a happy and productive life. Write Government Printing Office, Division of Public Documents, Washington 25, D. C.

* * *

Cancer Prevention through Colpophotography with the Camera. Discusses study and research of the subject and means of recording observations. Write Scientific Department, Exakta Camera Company, 705 Bronx River Road, Bronxville, New York.

* * *

Manual for Metabolic Balance Studies. Gives basic information for carrying out metabolic balance studies. Methods are those of Arthritis and Metabolic Diseases Service, Clinical Center, National Institutes of Health. (20 cents). Write U. S. Government Printing Office, Division of Public Documents, Washington 25, D. C.

* * *

Resuscitation of The Newborn. Prepared by Committee on Fetus and Newborn, American Academy of Pediatrics, with cooperation of American College of Obstetricians and Gynecologists, American Society of Anesthesiologists, American Hospital Association and American Public Health Association. Write American Academy of Pediatrics, 1801 Hinman Avenue, Evanston, Illinois.

35,000 Physicians Take Graduate Training

More than 35,000 physicians took graduate medical training in 1,400 American hospitals in 1957, according to the 32nd annual report on graduate medical education prepared by the American Medical Association's Council on Medical Education and Hospitals.

There were 10,198 graduates serving residencies, an increase of 305 over 1956-57, while 24,976 were serving residencies, an increase of 1,964 over the preceding year. The number of hospitals offering training increased from 1,372 to 1,400.

Of the available internship positions, only 17 per cent remained unfilled. Eighteen per cent of the residency positions were not filled, the report said. Many internship positions are filled by graduates of foreign medical schools. The report also showed:

The average number of intern positions for each hospital has increased during the past 10 years from 11.3 to 14.2.

Rotating internships, which must include training on the medical, surgical, pediatric and obstetric services, accounted for 87.6 per cent of the internships offered. The others were either straight internships in one field or mixed in two or three fields.

Church and nonprofit incorporated hospitals offered 78.9 per cent of the available internships; federal hospitals, 4.7 per cent; nonfederal governmental, 15.3 per cent, and proprietary (private), 1 per cent.

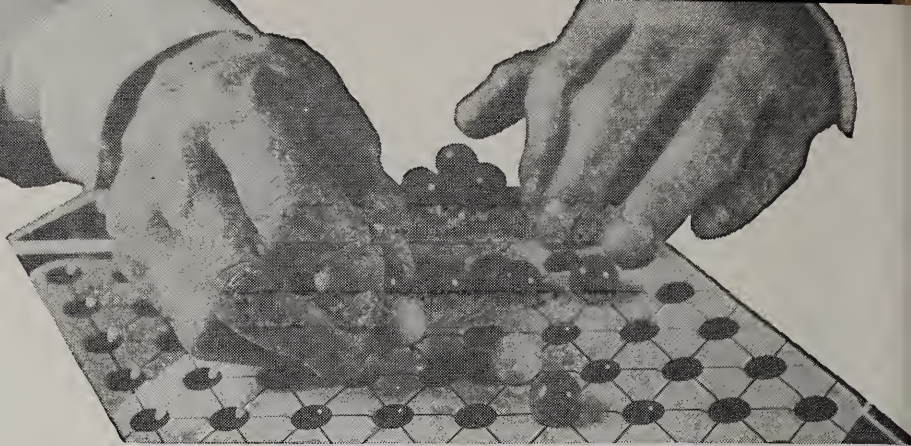
The average monthly cash stipend paid to interns continued to rise. Hospitals affiliated with teaching institutions raised their stipends from an average of \$141 in 1956-57 to \$155 in 1957-58. Non affiliated hospitals raised theirs from an average of \$177 to \$197.

Residency training was offered in 26 specialties and in general practice. Residencies in contagious diseases and malignant disease have been discontinued.

Approximately one-third of all residencies were offered in surgery, internal medicine, and obstetrics-gynecology. Residencies in aviation medicine, dermatology, obstetrics-gynecology, ophthalmology, and surgery showed an occupancy rate of 90 per cent or higher.

Tuberculosis as a cause of deaths has dropped from first to 13th place in the past half century. *Patterns of Disease*, a pharmaceutical publication, estimates that for every known case of tuberculosis in the United States there is one unknown tuberculous person—a total of some 800,000.

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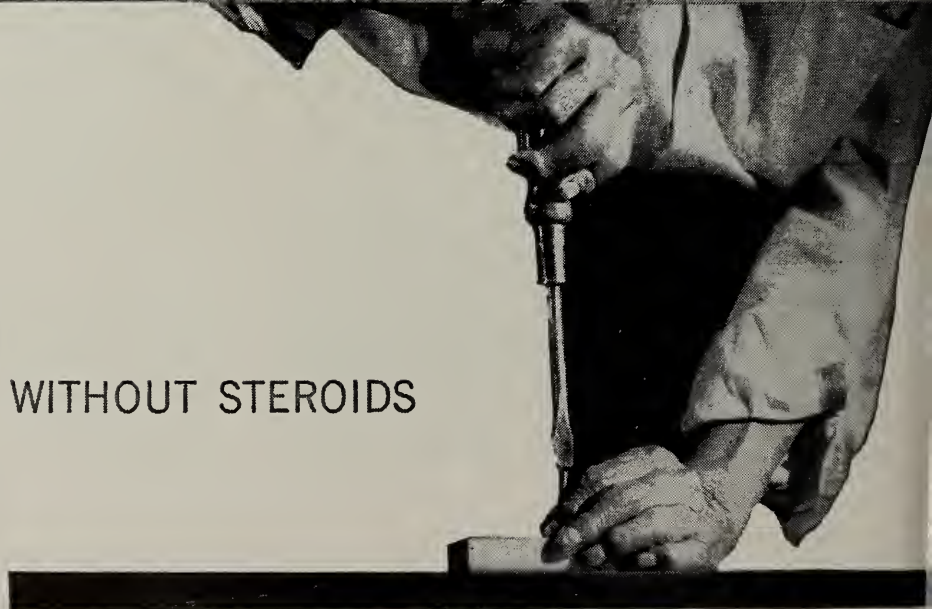
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COMING MEETINGS

American Medical Association, Annual Session, Atlantic, City, N. J., June 8-12.

Akron Academy of Ophthalmology and Otolaryngology, Postgraduate Course in Allergy and Endocrinological Aspects of Allergy, Ohio Building, Akron, May 4-6.

American Roentgen Ray Society, Cincinnati, September 21-25.

Bunts Institute, Cleveland Clinic Foundation, Course in Gastroenterology, May 13, 14.

Chest Disease Symposium for General Practitioners, Saranac Lake, N. Y., July 6-10.

Cincinnati General Hospital, Course in Diagnostic Roentgenology, Week Beginning June 15.

Cleveland Society of Anesthesiologists, Meeting, Tudor Arms Hotel, Cleveland, May 20.

National Tuberculosis Association and American Trudeau Society, Annual Meetings, Palmer House, Chicago, May 25-28.

Northwestern Ohio Medical Association, Findlay Country Club, October 7, all-day session; registration 9:00 a.m.; first speaker, 9:45 a.m.

Northern Tri-State Medical Association, 86th Annual Meeting, Marshall, Mich., May 7.

Ohio Chapter, American College of Surgeons, Annual Meeting, Statler Hotel, Cleveland, September 11, 12.

Ohio State Medical Golfers' Association, 1959 Tournament, Acacia Country Club, Cleveland, June 18.

Ohio State University, Department of Ophthalmology, Course in Perimetry for Office Assistants, July 13-15; Course for Ophthalmology Secretaries, July 16-17.

Ohio State Surgical Association, 1959 Annual Meeting, Cleveland, June 3-4.

Ohio State Radiological Society, Annual Meeting, Terrace-Hilton Hotel, Cincinnati, May 8-10.

The 1959 annual convention of the National Society for Crippled Children and Adults will be held November 29 to December 2 at the Palmer House in Chicago.

The number of veterans in civilian life continued to decline, according to a recent report of the Veterans Administration. As of February 28, 1959, there were 22,709,000 veterans in civilian life. The peak was reached in March, 1958, when there were 22,723,000.

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(Continued on Next Page)

STATE ASSOCIATION OFFICERS AND COMMITTEEMEN (Continued)

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ADAMS—Samuel B. Sonkin, President, Main St., West Union; Alexander Salamon, Secretary, Seaman. 3rd Wednesday, April, June, August, October and December.

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BUTLER—Clyde G. Chamberlin, President, 300 Rentschler Bldg., Hamilton; Mr. Charles G. Greig, Executive Secretary, 110 N. Third St., Hamilton. 4th Wednesday of alternate months.

CLERMONT—Cecil F. Barber, President, Felicity; Harry M. Breuer, Secretary, 224 George St., New Richmond. 3rd Wednesday, monthly.

CLINTON—Robert M. Cronebaugh, President, 116 N. Broadway, Blanchester; John K. Williams, Secretary, 100 W. Main St., Wilmington. 2nd Tuesday, monthly.

HAMILTON—J. Robert Hudson, President, 152 E. Fourth St., Cincinnati 2; Mr. Edward F. Willenborg, Executive Secretary, 152 E. Fourth St., Cincinnati 2. 3rd Tuesday, monthly. September through May.

HIGHLAND—J. Martin Byers, President, 316 Midway, Greenfield; Kenneth Lyle Upp, Secretary, 136 S. Washington St., Greenfield. 1st Wednesday, monthly.

WARREN—Thomas E. Fox, President, 309 Reading Rd., Mason; D. Paul Ward, Secretary, Box 85, Pleasant Plain. 2nd Tuesday, monthly.

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DARKE—Jesse L. Heise, President, Pittsburg; Emmett W. Arnold, Secretary, Court House, Greenville. 3rd Tuesday.

GREENE—Paul C. Vernier, President, 67 Xenia Drive, Fairborn; Quinten L. Erd, Secretary, S. Limestone, Jamestown. 2nd Thursday, monthly.

MIAMI—William W. Weis, President, 404 W. Wayne St., Piqua; John W. Gallagher, Acting Secretary, 407 W. High St., Piqua. 1st Friday, monthly.

MONTGOMERY—Alvin J. Carlson, President, 878 Reibold Bldg., Dayton; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Medical Bldg., Dayton 2. 1st Friday.

PREBLE—E. P. Trittschuh, President, 309 E. Main St., Lewisburg; Birna R. Smith, Secretary, 203 Commerce St., Lewisburg.

SHELBY—Clayton B. Conover, President, 316 S. Main Ave., Sidney; Ned A. Smith, Secretary, 739 Spruce St., Sidney. 1st Tuesday, monthly.

THIRD DISTRICT

ALLEN—Roger L. Tecklenberg, President, 700 Cook Tower, Lima; Thomas D. Allison, Secretary, 401 Steiner Bldg., Lima. 3rd Tuesday, monthly, except June, July, August.

AUGLAIZE—Robert J. Herman, President, 611 W. Mechanic St., Wapakoneta; Robert S. Oyer, Secretary, 310 Perry St., Wapakoneta. Called meetings.

CRAWFORD—Donald R. Wenner, President, 117 S. Poplar St., Bucyrus; Arnold Eicens, Secretary, 406 S. Sandusky St., Bucyrus. 3rd Thursday, monthly.

HANCOCK—M. Wesley Feigert, President, Ohio Bank Bldg., Findlay; Benjamin H. Saunders, Jr., Secretary, 1900 S. Main St., Findlay. 3rd Tuesday, monthly.

HARDIN—Raymond G. Schutte, President, 110 E. Columbus St., Kenton; Jack C. Lindsey, Secretary, 214 N. Main St., Kenton. 2nd Tuesday, monthly.

LOGAN—Charles A. Browning, Jr., President, 445 E. Columbus Ave., Bellefontaine; Paul E. Hooley, Secretary, N. Main St., DeGraff. 1st Friday, monthly.

MARION—Thomas N. Quilter, President, 1040 Delaware Ave., Marion; Robert L. Stuber, Secretary, 399 E. Church St., Marion. 1st Tuesday, monthly.

MERCER—Julius Schwieger, President, Fort Recovery; Terrence J. Kerrigan, Secretary, 204 W. North St., Coldwater. 3rd Thursday, monthly.

COUNTY SOCIETIES' OFFICERS AND MEETING DATES (Continued)

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VAN WERT—Jack H. Cox, President, 301 N. Washington St., Van Wert; Ralph E. Rasor, Jr., Secretary, 507 S. Washington St., Van Wert.

WYANDOT—Clarence B. Schoolfield, President, 206 S. Main St., Upper Sandusky; Franklin M. Smith, Secretary, E. Saffle Ave., Box 68, Sycamore. 2nd Tuesday, monthly, except July and August.

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FULTON—Edwin R. Murbach, President, 224 N. Defiance St., Archbold; Robert A. Ebersole, Secretary, 203 DeGross Ave., Archbold. 2nd Tuesday, monthly.

HENRY—Edwin C. Winzeler, President, 812½ N. Perry St., Napoleon; Thomas F. Tabler, Secretary, 332 Railway Ave., Holgate. 1st Tuesday, monthly.

LUCAS—Maurice A. Schnitker, President, 1006 Secor Hotel, Toledo 3; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Blvd., Toledo 10. 3rd Tuesday, monthly.

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PAULDING—Edythe C. Pritchard, President, 509 N. Williams St., Paulding; D. E. Farling, Secretary, Main St., Payne. 3rd Wednesday, monthly.

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WOOD—Stewart J. Smith, President, 106 N. Main St., Bowling Green; Richard L. Pearce, Secretary, 320 S. Main St., Bowling Green. 3rd Thursday, monthly.

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ASHTABULA—Lewis H. Roth, President, 80 S. Broadway, Geneva; Albin F. Urankar, Secretary, Ashtabula Gen. Hospital, Ashtabula.

CUYAHOGA—Chester R. Jablonoski, President, 7211 Broadway, Cleveland; Mr. Robert A. Lang, Executive Secretary, 2009 Adelbert Rd., Cleveland. 2nd Tuesday, monthly.

GEAUGA—George Dandalides, President, Chardon Medical Center, Chardon; Alton W. Behm, Secretary, 112 South St., Chardon. 2nd Friday, monthly.

LAKE—Richard W. McBurney, President, 124 S. St. Clair St., Painesville; Mrs. Owen A. McLaren, Executive Secretary, 1051 Cadle Ave., Mentor.

SIXTH DISTRICT

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STARK—John R. Seesholtz, President, 1645 Cleveland Ave., N. W., Canton; Mr. E. M. Sprunger, Executive Secretary, 405 Fourth Street, Canton 2. 2nd Thursday, monthly, except May, June, July, August and September.

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MONROE—Byron Gillespie, Secretary, South Main Street, Woodsfield.

TUSCARAWAS—Chester A. Bennett, President, 533 Wooster Ave., Dover; George D. Woodward, Secretary, 201 Boulevard, Dover. 2nd Thursday, monthly.

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FAIRFIELD—Lloyd L. Kersell, President, 130 Union St., Lancaster; Arthur B. VanGundy, Secretary, 843 N. Columbus St., Lancaster. 2nd Tuesday, monthly.

GUERNSEY—Jesse B. Kellum, President, 840 Wheeling Ave., Cambridge; Thomas D. Swan, Secretary, 651 Wheeling Ave., Cambridge. 1st Thursday, monthly.

LICKING—Kurt J. Fleisch, President, 125 Hudson Ave., Newark; Jay Ross Wells, Secretary, 375 Granville St., Newark. Last Tuesday, monthly.

MORGAN—A. H. Whitacre, President, Chesterhill; C. E. Northrup, Secretary, Corner Main and Seventh St., McConnelsville. Called meetings.

MUSKINGUM—J. Herbert Bain, President, 67 W. Main St., New Concord; William A. Knapp, Secretary, 1025 Maple Ave., Zanesville. 1st Tuesday, monthly.

NOBLE—Charles F. Thompson, President, Caldwell; E. G. Ditch, Secretary, Caldwell. 1st Tuesday, monthly.

PERRY—Charles E. Bope, President, Somerset; O. D. Ball, Secretary, 203 N. Main St., New Lexington. Called meetings.

WASHINGTON—William R. Stewart, President, 407 Second St., Marietta; Donald S. Williams, Secretary, 222 Third St., Marietta. 2nd Wednesday, monthly.

NINTH DISTRICT

GALLIA—Thomas W. Morgan, President, Holzer Hospital, Gallipolis; Norman W. Pinschmidt, Secretary, Gallipolis Clinic, 52 State Street, Gallipolis. 3rd Thursday, monthly.

HOCKING—George B. Watson, President, Box 296, Adelphi; Howard M. Boocks, Secretary, Court House, Logan. Indefinite meeting dates.

JACKSON—Tom Washam, President, 35 Vaughn St., Jackson; Brinton J. Allison, Secretary, 267 Ralph St., Jackson. Called meetings.

LAWRENCE—Gerard C. Geswein, President, 1626 S. Sixth St., Ironton; George Newton Spears, Secretary, 2213 S. Ninth St., Ironton. Monthly meetings on call.

MEIGS—Charles J. Mullen, President, 210½ E. Main St., Pomeroy; Selim J. Blazewicz, Secretary, 112½ E. Main St., Pomeroy. Last Wednesday, monthly.

PIKE—Paul H. Jones, President, Stockdale; George W. Cooper, Secretary, Picketon. 1st Tuesday, monthly.

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VINTON—Richard E. Bullock, President, McArthur; H. D. Chamberlain, Secretary, W. Main St., McArthur.

TENTH DISTRICT

DELAWARE—Max W. Livingston, President, 28 North Vernon, Sunbury; Edward C. Jenkins, Secretary, c/o Mrs. Mabel Barrett, Jane M. Case Hospital, Delaware. 3rd Tuesday, monthly.

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COUNTY SOCIETIES' OFFICERS AND MEETING DATES (Continued)

FAYETTE—H. Wm. Payton, President, 36 S. Main St., Jeffersonville; Marvin H. Roszmann, Secretary, 107 N. North St., Washington C. H. 2nd Tuesday, monthly.

FRANKLIN—James L. Henry, President, 244 E. Park St., Grove City; Mr. William Webb, Executive Secretary, 79 East State Street, Columbus 15. Meetings in January, February, March, May, September, November and December.

KNOX—Henry T. Lapp, President, 4 Public Square, Mt. Vernon; Thomas L. Bogardus, Secretary, 50 Public Square, Mt. Vernon. Quarterly meetings.

MADISON—William T. Bacon, President, 40 E. First St., London; Paul G. H. Wolber, Secretary, 40 E. First St., London. 2nd Wednesday, monthly.

MORROW—Andrew Maciurak, President, 119 E. Main St., Cardington; William S. Deffinger, Secretary, Marengo. First Tuesday, monthly.

PICKAWAY—Henry H. Swope, President, 233 N. Court St., Circleville; Edward L. Montgomery, Secretary, 108 Seyfert Ave., Circleville. 1st Friday, monthly.

ROSS—Robert E. Quinn, President, 30 N. Walnut St., Chillicothe; G. Howard Wood, Secretary, 134 W. Main St., Chillicothe. 1st Thursday, monthly.

UNION—Paul R. Zaugg, President, 130 N. Maple St., Marysville; May B. Zaugg, Secretary, 130 N. Maple St., Marysville. 2nd Tuesday, monthly.

ELEVENTH DISTRICT

ASHLAND—R. Lee Schafer, President, 203 Maple Street, Ashland; Wayne C. Smith, Secretary, 140 Claremont Ave., Ashland. 1st Friday, monthly, except July, August.

ERIE—Richard F. Hoffman, President, Providence Hospital, Sandusky; Edward P. Gillette, Jr., Secretary, 410 Columbus Ave., Sandusky. Monthly meeting date varies.

HOLMES—Clyde Bahler, President, Walnut Creek; Luther W. High, Secretary, R. F. D. 4, Millersburg. 2nd Wednesday, monthly.

HURON—Walter A. Drury, President, Box 269, Willard; John V. Emery, Secretary, Box 269, Willard. 2nd Wednesday, March, June, September and December.

LORAIN—Denis A. Radefeld, President, 209 Sixth St., Lorain; Mrs. C. Ruth Zealley, Executive Secretary, 311 Elyria Block, Elyria. 2nd Tuesday, monthly.

MEDINA—Robert E. Smith, President, 403 East Liberty St., Medina; William G. Halley, Secretary, 115 Bank Street, Lodi. 3rd Thursday, monthly.

RICHLAND—Riley E. Frush, President, 36 S. Mulberry St., Mansfield; James O. Ludwig, Secretary, 336 Sturges Ave., Mansfield. 3rd Thursday, monthly.

WAYNE—Ralph I. Cottle, President, 230 N. Market St., Wooster; Robert E. Schulz, Secretary, Wooster Community Hospital, Wooster. 2nd Wednesday, monthly.

THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

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2863 Richmond Road, Cleveland 24

Vice-Presidents: 1. Mrs. Lester Sontag
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2. Mrs. Myron Thomas
Box 4, Garrettsville
3. Mrs. Herbert Warm
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President-Elect: Mrs. George T. Harding III
430 E. Granville St., Worthington

Recording Secretary: Mrs. John Dickie
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19201 Van Aken Blvd.,
Shaker Heights 22

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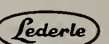
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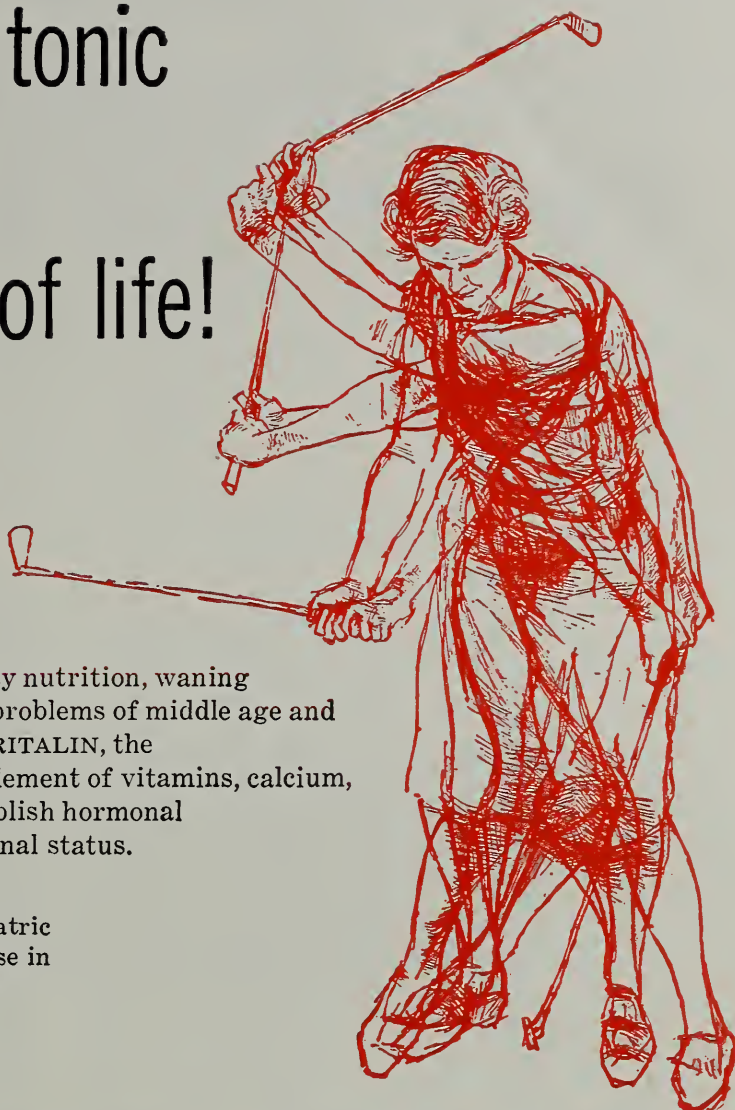
CAPSULES—14 VITAMINS—11 MINERALS

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A sense of frustration and inadequacy, faulty nutrition, waning gonadal function—RITONIC meets all these problems of middle age and senile let-down. The unique combination of RITALIN, the *safe* central stimulant, with a balanced complement of vitamins, calcium, and hormones acts to renew vitality, re-establish hormonal and anabolic benefits, and improve nutritional status.

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for your geriatric patients, your middle-aged patients and your postmenopausal patients.

Each Ritonic Capsule contains:

<i>Ritalin® hydrochloride</i>	5 mg.
<i>methyltestosterone</i>	1.25 mg.
<i>ethinyl estradiol</i>	5 micrograms
<i>thiamin (vitamin B₁)</i>	5 mg.
<i>riboflavin (vitamin B₂)</i>	1 mg.
<i>pyridoxin (vitamin B₆)</i>	2 mg.
<i>vitamin B₁₂ activity</i>	2 micrograms
<i>nicotinamide</i>	25 mg.
<i>dicalcium phosphate</i>	250 mg.

Dosage: One Ritonic Capsule in mid-morning and one in mid-afternoon.

Supplied: Ritonic CAPSULES; bottles of 100.

References: 1. Natenshon, A. L.: J. Am. Geriatrics Soc. 6:534 (July) 1958.
2. Bachrach, S.: To be published.

RITALIN® hydrochloride (methylphenidate hydrochloride CIBA)

C I B A SUMMIT, N. J.

2/2659MK

The Physician's Bookshelf

(Books received from publishers. *The Journal* is not obligated to list herein every book received. It will try to list those which appear to be of greatest interest.)

* * *

Physical Diagnosis, by John A. Prior, M. D., and Jack S. Silberstein, M. D. (\$7.50, *The C. V. Mosby Company, St. Louis 3, Missouri*.) The authors have emphasized the importance of adequate medical history and have introduced a graphic method of recording the history, which has proven to be of considerable value in teaching.

In their description of physical findings, they have emphasized the importance of recognizing variations of normal and have exhibited restraint in the listing of abnormal physical signs.

Concise as it is, the text includes excellent chapters on examination of male and female genitalia, extremities, nervous system, motor-skeletal system, etc. All sections are clearly and most attractively illustrated.

Vascular Surgery, by Geza de Takats, M. D. (\$17.50, *W. B. Saunders Company, Philadelphia 5, Pa.*) The author presents here a comprehensive treatment of his subject with frequent references to applied physiology.

It is clear that he is recommending treatment of a whole patient and not simply describing technical procedures. The text is highly recommended not only to surgeons interested in this rapidly expanding field but also as a reference for those concerned with the medical aspects of vascular disease.

The Sedimentation Rate of Human Erythrocytes, by Frank Wright, M. D. (\$2.50, *Vantage Press, Inc., New York 1, N. Y.*)

Amino Acids and Peptides with Antimetabolic Activity, by G. E. W. Wolstenholme, O. B. E., and Cecilia M. O'Conner, B. Sc. (\$8.75, *Little, Brown & Co., Boston 6, Mass.*)

Long-Term Illness; Management of the Chronically Ill Patient, by Michael G. Wohl, M. D. (\$17.00, *W. B. Saunders Co., Philadelphia 5, Pa.*)

Dorland's Pocket Medical Dictionary. (\$4.50, 20th Edition, *W. B. Saunders Co., Philadelphia 5, Pennsylvania*.)

Psychotherapeutic Drugs, by Ashton L. Welsh, M. D. (\$4.75, *Charles C. Thomas, Publisher, Springfield, Ill.*)

Good Neighbors; The Rise of Community Welfare Councils, by Elizabeth Ogg, (25 cents, Public Affairs Pamphlet 277, *Public Affairs Committee, 22 E. 38th St., New York 16, N. Y.*)

Bone Tumors, by Louis Lichtenstein, M. D. (\$12.00, Second edition, *The C. V. Mosby Co., St. Louis 3, Mo.*)

Current Theories on the Etiology of Mongolism, by George S. Baroff, reprinted from *Eugenics Quarterly*, Vol. 5, No. 4, Dec., 1958. (*American Eugenics Society, 230 Park Ave., New York 17, N. Y.*)

Psychiatry in General Practice, by J. A. Weijel, M. D. (\$7.00, *Elsevier Press, Inc., Houston 2, Texas*.)

Young Children in Hospitals, by James Robertson, introduction by Milton J. E. Senn, M. D. (\$3.00, *Basic Books, Inc., New York 3, N. Y.*)

Practical Dermatology, by George M. Lewis, M. D. (\$8.00, second edition, *W. B. Saunders Co., Philadelphia 5, Pa.*)

Clinical Orthopaedics; No. 12, Rehabilitation, by Anthony F. DePalma, M. D. (\$7.50 single copies, \$6.00 sustaining members, 3 issues per year, *Medical Department, J. B. Lippincott Co., Philadelphia 5, Pa.*)

Fracture Surgery: A Textbook of Common Fractures, by Henry Milch, M. D., and Robert Austin Milch, M. D. (\$17.50, *Paul B. Hoeber, Inc., Medical Book Department, Harper & Brothers, New York 16, N. Y.*)

The Management of Fractures and Dislocations: An Atlas, Volumes I and II, by Anthony F. DePalma, M. D. (\$35.00, set of 2 volumes, *W. B. Saunders Co., Philadelphia 5, Pa.*)

Psychopharmacology Frontiers, by Nathan S. Kline, M. D. (\$10.00, *Medical Book Department, Little, Brown & Co., Boston, Mass.*)

Reminiscences & Adventures in Circulation Research, by Carl J. Wiggers, M. D. (\$9.75, *Grune & Stratton, Inc., New York 16, N. Y.*)

Color Atlas of Morphologic Hematology, by Geneva A. Daland. (\$6.75, Revised edition, *Harvard University Press, Cambridge 38, Mass.*)

Thrills and Regressions, by Michael Balint, M. D. (\$4.00, *International Universities Press, New York 11, N. Y.*)

Mankind's Children; The Story of UNICEF, by Robert L. Heilbroner, (25 cents, Public Affairs Pamphlet No. 279, *Public Affairs Pamphlets, New York 16, N. Y.*)

Antivert[®] stops



VERTIGO

Each ANTIVERT tablet contains:

Meclizine (12.5 mg.)—most effective antihistaminic to control vestibular dysfunction.¹

Nicotinic acid (50 mg.)—the drug of choice for prompt vasodilation.^{2,3}

Advantage of "dual therapy" confirmed:

Menger found ANTIVERT "improved or controlled symptoms in virtually 90% of vertiginous patients."²

Indications: Meniere's syndrome, arteriosclerotic vertigo, labyrinthitis, and streptomycin toxicity. Also effective in recurrent headache, including migraine.

Dosage: one tablet before each meal.

Supplied: bottles of 100 blue-and-white scored tablets. Prescription only.

References: 1. Charles, C. M.: *Geriatrics* 2:110 (March) 1956. 2. Menger, H. C.: *Clin. Med.* 4:313 (March) 1957. 3. Shuster, B. H.: *M. Clin. North America* 40:1787 (Nov.) 1956.



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New York 17, N. Y.
Science for the world's well-being

Civil Defense Review

Some Recent Developments in the CD Field And Activities in the Program

The Texas Defense and Disaster Relief Headquarters, in the February issue of its *Texas Defense Digest*, reports that the Southwest Texas Methodist Hospital will have in addition to its five stories above ground a survival complex of two additional floors below ground. The hospital is scheduled for completion in 1961. The part below ground will be constructed of reinforced concrete and will be designed to withstand any disaster. It will also be almost self-sufficient with its own power plant, underground water wells and food stocks. Other advanced features include a heliport where emergency patients can be flown by helicopter service; a closed-circuit TV system which will keep the nurse in contact with each patient; tele-thermometers capable of taking the patient's temperature from a distance; an electron beam generator which will disinfect virtually everything touched by human hands; and radar ranges to cook a full course meal by microwaves in 45 seconds. The new hospital is approved by the Office of Civil and Defense Mobilization.

* * *

The resources of the Flying Physicians Association, Inc., an organization of 1,500 civilian physicians who are licensed pilots, will be made available to state civil defense organizations for use in natural disaster or civil defense emergencies. The FPA, with national headquarters at Tulsa, Oklahoma, has, in addition to trained physician-pilots, approximately 1,500 immediately available planes, 3,000 nurses and medical supplies. These resources should assist in the need of state and local governments for the greatest possible self-sufficiency in time of disaster. The Committee on Disaster Medical Care of the American Medical Association has requested the civil defense committees of state medical associations to cooperate fully with the Flying Physicians Association in making its resources available in disaster situations.

* * *

Members of the American College of Radiology have been requested by the Office of Civil and Defense Mobilization to furnish technical assistance and guidance in monitoring techniques and radiological defense planning. The chancellors of the American College of Radiology have endorsed the proposal and asked their members to assist by volunteering their services to state and

local civil defense authorities. OCDM believes that the specialized education and experience of these 5,000 radiologists are needed in developing a national operational capability in radiological defense. Such capabilities would assure rapid and accurate evaluation of the extent and intensity of fallout across the nation in the event of nuclear attack.

* * *

Two staff members of the National Naval Medical Center, Bethesda, Maryland, have built a substitute for the human body with simulated tissue, blood supply, veins, arteries and pulse. The substitute body responds to touch and surgery much like the human body and will be a most important medical teaching aid for first aid and medical students who will be able to rehearse wound-closing procedures, including the clamping and tying of blood vessels, suturing and bandaging.

The inventors are Captain John V. Niiranen, head of the training aids department at the Navy Dental School, and Paul H. Tanner, a civilian training officer. They have assigned their patent to the Navy.

* * *

Recently it was reported that Lt. General Lewis B. Hershey, director of the Selective Service System, suggested that men not inducted in the Armed Services might be channeled into civil defense. General Hershey made this suggestion in testimony before the Committee on Armed Services of the House of Representatives. The Director of the Office of Civil and Defense Mobilization, Governor Leo A. Hoegh, disagrees with this suggestion. Governor Hoegh said he prefers the voluntary basis. He believes citizens everywhere can be counted upon to lend their help in a civil defense emergency without being subjected to conscription.

New Editor Appointed For Today's Health

Appointment of Kenneth N. Anderson, associate editor of *Popular Mechanics* magazine, to the position of editor of *Today's Health* has been announced by AMA Executive Vice-President F. J. L. Blasingame, M. D.

Mr. Anderson succeeds James M. Liston, who resigned to join the staff of *American Home* magazine.

the means *(second to none)*
to end nausea and vomiting

Trilafon®
perphenazine

INJECTION • SUPPOSITORIES • REPETABS • TABLETS

- *leads* all phenothiazines in effective antinauseant action
- *frees* patients from daytime drowsiness
- *avoids* hypotension
- *proved* and *published* effectiveness in practically all types of nausea or emesis

FOR RAPID CONTROL OF SEVERE VOMITING

TRILAFON INJECTION

5 mg. ampul of 1 cc.

Relief usually in 10 minutes¹...nausea and vomiting controlled in up to 97% of patients²... virtually no injection pain.

ALSO NEW TRILAFON SUPPOSITORIES

4 mg. and 8 mg.

AND FOR ORAL THERAPY

TRILAFON REPETABS®

8 mg.—4 mg. in outer layer for *prompt effect*,
4 mg. in inner core for *prolonged action*

TRILAFON TABLETS

2 mg. and 4 mg.

(1) Ernst, E. M., and Snyder, A. M.: *Pennsylvania M. J.* 61:355, 1958.

(2) Preisig, R., and Landman, M. E.: *Am. Pract. & Digest Treat.* 9:740, 1958.

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In Our Opinion:

AMA EXPANDS PR SERVICE FOR MEMBERS

Streamlined and expanded, AMA's new Communications Division is ready to give you better PR assistance than ever before. Here's a roadmap to the division's services and personnel. Make use of them:

Special Services—Carol Towner, manager—assists county and state societies with their PR programs . . . interprets the services of the AMA to public and profession . . . produces and distributes PR literature . . . also publishes the PR Doctor.

Media Relations—position of manager unfilled—helps newspaper, TV, radio and magazine writers in the preparation of health and medical materials . . . prepares and loans exhibits . . . serves as consultant for medical society TV and radio shows . . . issues a weekly scientific news release to daily papers.

Services to Officers—Howard Cartwright, manager—arranges speaking engagements of AMA's president, president-elect and other officers.

Program Development—Debs Meyers, manager—serves as PR consultant to AMA's councils, committees and departments.

AMA News—James Reed, editor—a bi-weekly newspaper for doctors featuring socio-economic medical news.

Today's Health—Kenneth N. Anderson, editor—a monthly health magazine for the public.

Medical Motion Pictures and Television—Ralph Creer, manager—maintains a loan library of medical films . . . assists producers of medical films . . . arranges film program for AMA's annual and clinical meetings.

THESE CIRCULARS SHOULD BE FILED IN YOUR WASTE BASKET

If you have been receiving circulars from an outfit known as Rittenhouse & Revere, Inc., Albuquerque, New Mexico, it is suggested you drop the circulars into your wastepaper basket and forget all about having received them.

This is a high-powered promotional firm. It offers to build up your practice at a fast clip, providing you purchase some of their wares such as gadgets for treating this or that and its remedies for obesity, kidney diseases, bladder infections, or what-have-you. Those who do purchase

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

such materials are rewarded in this fashion: Folks in the area are sent circulars talking about various diseases and what should be done for them, accompanied by a recommendation that they see Doctor So-and-So for advice and treatment—namely those who bought the equipment and cure-alls.

Bureau of Investigation of the AMA has their number; so does the Better Business Bureau. 'Nuff said.

GEMS OF WISDOM ON JUDICIAL PROCEEDINGS

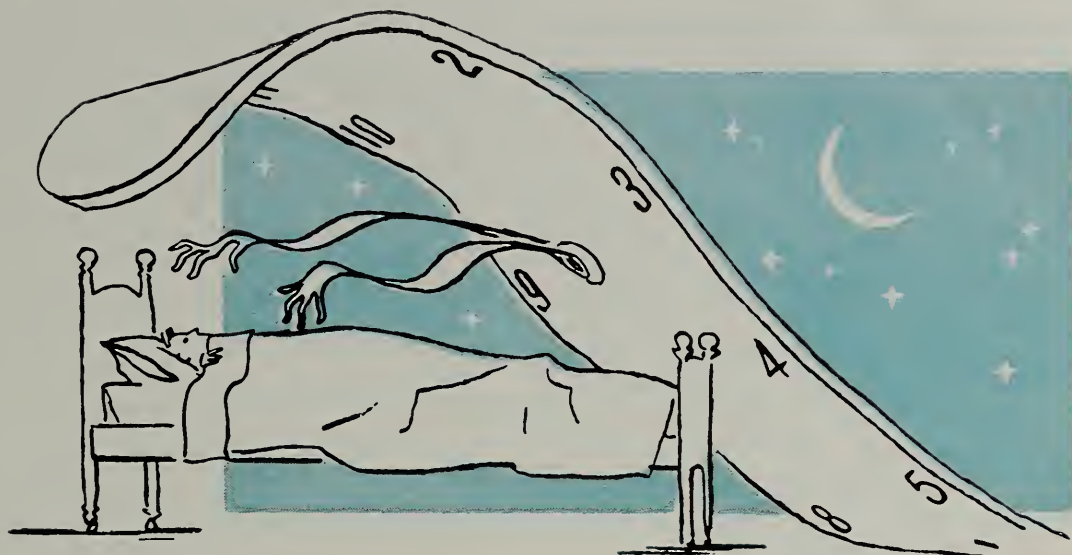
Judicial Committee of the Cincinnati Academy of Medicine, which handles complaints and grievances, (and does a fine job of it, by the way) offered these gems of wisdom to the Academy membership recently:

"Members should be careful in their correspondence about accusing other physicians of being unethical. Officers of the Academy request that members follow the Code of Professional Relationships for the Practice of Industrial Medicine. Medical directors should notify the family physician when there is to be an examination for benefits under a pension or sick leave plan. A written or printed notice, is preferred to a telephone call.

"In complaints between physicians, the Judicial Committee gives considerable weight to a letter or printed form that furnishes adequate information to the family physician. Correspondence of physicians concerning employees is often considered by executive boards and personnel officers of industrial organizations; also, the correspondence is presented to a board having union representatives and, in some instances, unjustifiable criticism results.

"The Committee would also like to point out that it does not set fees, and if there is no fee agreement between doctor and patient before treatment, the charge should not be more than the average fee established in this area. Basing the fee on ability to pay is not justifiable in cases of insurance claims and damage awards. A patient carrying more than one insurance policy should not be charged on the basis of how much can be collected from each policy. The best rule is to charge a reasonable fee for medical services rendered.

"The Judicial Committee must be fair to both the physician and the patient; the Committee will



Night hours need not be long for the asthmatic

The acute attack of asthma is far more terrifying
at night. Keep your patient serene throughout
the night, and comfortable all day, too with*



Luasmin

Luasmin capsules two or three times a day
and a capsule with an enteric coated tablet at
night bring your patient round the clock relief.

Each capsule or tablet contains:

Theophylline Sodium Acetate 0.2 Gm.
Ephedrine Sulfate 30 mg.
Sodium Phenobarbital 30 mg.

Supplied: Capsules and enteric coated
(delayed action) tablets.

Note the adequate therapeutic dose of ephedrine balanced by the correct dose of phenobarbital.

*Ethan Allen Brown, N.E. J. Med., 223:843.

F. K. Albrecht, Mod. Mgmt Clin. Med., P674,
Williams & Wilkins.

F. W. Wittich, J. Am. Ger. Soc., 3:239, 1955

Brewer
EST. 1945

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Worcester, Mass.

not permit its functions to be used as a club—it considers all complaints on the basis of merit.”

There are some good ideas in the above for similar committees of other county medical societies to follow; as well as plenty of sound advice for physicians generally.

PROGRAM IDEA WITH CONSIDERABLE MERIT

The Trumbull County Medical Society has decided to devote all of its meetings during the ensuing year to discussions of social, economic, legislative and organizational matters. Members will be expected to obtain their refresher training and keeping-up-with medicine information through reading, organized postgraduate meetings, medical conventions and hospital staff meetings.

This will be an interesting experiment. The idea has a lot to be said in its favor, providing, of course, the individual members don't neglect to take advantage of opportunities offered in other ways for PG work. Certainly, there is the need in the yearly activities of most county medical societies for more emphasis at meetings on the social - economic - legislative problems confronting medicine.

GOING ABROAD? IF SO BETTER GET THIS BOOKLET

Going to travel in foreign countries this summer? Do you have patients who are planning a trip abroad and want to know something about immunization, quarantine measures, etc?

If so, it is suggested you get the booklet, "Immunization Information for International Travel," published by the U. S. Department of Health Education and Welfare, Public Health Service and available for 30 cents per copy from the Superintendent of Documents, Government Printing Office, Washington 25, D. C.

It contains such information as: documents and immunizations required; immunizations recommended; where immunizations may be obtained; list of countries with required and recommended immunizations; designated Yellow Fever vaccination centers.

WAYS TO IMPROVE PRESS RELATIONS

Public relations chairmen of County Medical Societies in Ohio should heed the lessons pointed up in a recent survey of 73 newspaper editors and 320 physicians by University of North Carolina journalism professor Roy Carter which uncovered some flaws in the doctor-press structure.

The survey—which was financed partly by the Medical Society of North Carolina —disclosed

that half the daily newspaper editors questioned didn't even know about their local medical societies' information committees. Their most frequent suggestion was that societies provide a list of spokesmen who could clear medical news.

Almost all the editors thought press codes would help matters, but only half of them were familiar with such codes. Most frequently approved provision was for a round-the-clock hospital spokesman.

Only one-third of the editors believed adequate medical care was available to the indigent in their communities, but here again this opinion seemed to stem from lack of knowledge. Newspapermen who were frequently under the care of physicians tended to give a favorable response to the question, indicating that societies ought to orient editors on the medical facilities and indigent care practices in their communities.

The fact that only one editor in six was willing to check his facts by showing a doctor an article before it appeared in print probably would be altered if doctors made it clear they would not attempt to rewrite the story—just verify its accuracy.

How do physicians feel about newspapermen? The survey showed that experience with newspapermen and a favorable opinion of them go hand in hand. Medical society officers, PR chairmen and older doctors felt for the most part that they had been treated fairly by the press. No society officer experienced as a news source could recall being quoted in an embarrassing manner. Almost all had given permission—or would have—to be quoted by name. This suggests that a society spokesman, who develops good relationships with newspapermen over a period of years, is the most satisfactory news source for everybody concerned.

Russians Are Using Oral Polio Vaccine on Large Scale

Dr. Albert B. Sabin, University of Cincinnati College of Medicine and Children's Hospital Research Foundation scientist, left early in May for Antwerp, Belgium, to attend an international symposium on encephalitis. He then went to Czechoslovakia and Russia to study results of their use of his oral vaccine for poliomyelitis.

Dr. Sabin pointed out the vaccine is being administered in Russia to about 100,000 children daily. They aim at 10 million this year and eventually the entire population.

The Russians used the material sent them from Cincinnati as "seed" to make their own material.

The results of administering Delalutin before the 12th week of gestation to 82 women with habitual abortion were reported recently by Reifenstein.¹ Every patient had experienced at least three consecutive abortions immediately preceding the treated pregnancy. More than 68% of these women were delivered successfully and uneventfully following Delalutin therapy.

Boschann,² in a study of pregnancies with threatened abortion, found that:

37% of 73 pregnancies were carried to term without progestational therapy

64% of 42 pregnancies were salvaged by progesterone

83% of 73 pregnancies were salvaged by Delalutin

Eichner,³ found that with Delalutin fetal salvage of infants below term weight (1000 to 2000 gm.) was significantly improved.

108 (76%) of 142 babies of this birth weight survived without progestational therapy.

16 (100%) of 16 babies of this birth weight survived with Delalutin therapy.

A comparison study was made of a group of repeated aborters treated with Delalutin, and a group with a similar history treated with bed rest and sedation.⁴ Pregnancy salvage with Delalutin was twice that of the control group. Delalutin was found to be "highly active," well-tolerated and long-acting.

Delalutin offers these advantages over other progestational agents:

- longer-acting and more sustained therapy
- more effective in producing and maintaining a completely matured secretory endometrium
- no androgenic effect
- more concentrated solution requires injection of less vehicle
- unusually well-tolerated, even in large doses
- requires fewer injections
- low viscosity makes administration easier

DELALUTIN is also potent and safe therapy for: threatened abortion; post-partum after-pains; amenorrhea, primary and secondary; dysfunctional uterine bleeding not associated with genital malignancy; infertility with inadequate corpus luteum function; production of secretory endometrium and desquamation during estrogen therapy; premenstrual tension; dysmenorrhea; cyclomastopathy, mastodynia, adenosis and chronic cystic mastitis.

Administration and Dosage: Because of its low viscosity, Delalutin may be administered with a small gauge needle (deep intragluteal injection). Complete information on administration and dosage is supplied in the package insert.

Supply: Delalutin is available in vials of 2 and 10 cc., each cc. containing 125 mg. of hydroxyprogesterone caproate in sesame oil, and benzyl benzoate.

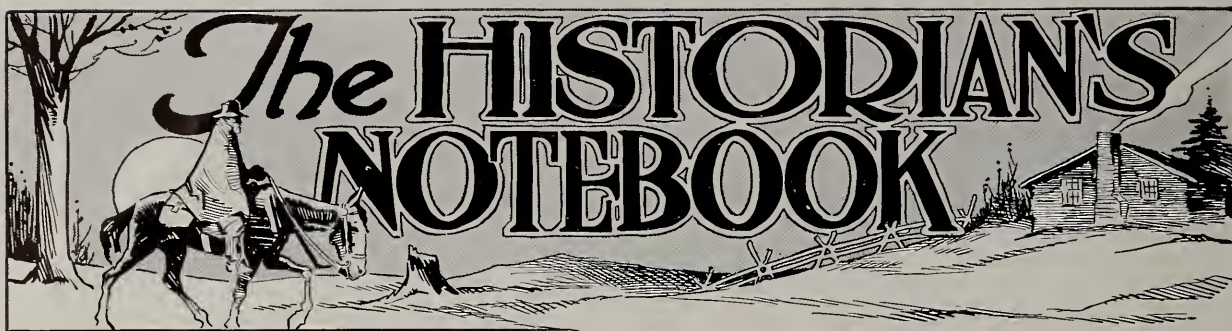
References: 1. Reifenstein, E. C., Jr.: *Annals N. Y. Acad. Sci.* 71:762 (July 30) 1958. 2. Boschann, H-W.: *ibid.*, p. 727. 3. Eichner, E.: *ibid.*, p. 787. 4. Hodgkinson, C. P.; Igna, E. J., and Bukeavich, A. P.: *Am. J. Obst. and Gyn.* 76:279, 1958.

SQUIBB



Squibb Quality—the Priceless Ingredient

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A Ghoulish Tale of Three Cities

LINDEN F. EDWARDS, Ph. D.

PART I

A ZANESVILLE, Ohio, policeman had just replaced his watch in his vest pocket, after noting in the dimness of the corner street light that the hour was 2:30 a. m., when the driver of a handsome sorrel horse hitched to a light spring-wagon stopped to inquire if the street he was on happened to be the National Road and if he were headed in the right direction for Columbus. After replying in the affirmative to both questions the patrolman, being typically inquisitive and suspicious of strangers wandering about at that hour, engaged the stranger in conversation.

Meanwhile, he walked around the conveyance, poked his fingers in the large sacks which were loaded in the back of the wagon and asked the driver what they contained. When he was told that it was corn he glanced suspiciously at the stranger and bruskiy remarked that it felt too soft for corn. At that juncture the driver suddenly arose from his seat and applied the whip to the horse which bounded down the street in a dead run.

With this sudden turn of events the patrolman blew three short blasts on his whistle to signal his fellow patrolman on the adjoining beat. After a hurried conference the two ran to the nearest livery stable where they obtained a horse and buggy and took off in hot pursuit of the fleeing stranger. They finally caught up with him as they were approaching the village of Brownsville. One of the officers shot off his revolver into the air over the fleeing man's head hoping to frighten him into stopping. Instead the latter returned the fire, the bullet finding its mark in the hand of one of the pursuing officers, and applied the whip more viciously.

As luck would have it there was a toll-gate on the highway at the west end of the village

The Author

● Dr. Edwards, Columbus, is Professor of Anatomy, The Ohio State University College of Medicine.

and the officers were jubilant over the thought that they had their prey trapped. The stranger realizing that time was too short for him to pay the toll and for the gate to be opened allowing him to pass through in his mad flight, drove the horse through the gate with a terrific crash. Thereupon he abandoned the horse, vehicle and his cargo and made his escape into an adjoining woods.

A Ghastly Cargo

Arriving upon the scene shortly thereafter the officers proceeded to open the sacks. To their surprised horror and amazement they discovered the contents to be four dead human bodies. With this discovery they requested the toll-gate keeper to rouse the neighbors and to organize them into search parties to scour the countryside for the escaped stranger. Being unable to identify the bodies and anxious to report their discovery, the officers returned post-haste to Zanesville where a large crowd of curious spectators soon gathered to view the ghastly cargo.

Identification of the bodies was soon made and an inspection of the graves in Woodlawn Cemetery, where they had been buried recently, disclosed their empty caskets thus confirming the identifications. More than a casual examination of the despoiled graves was required, because there were no tell-tale signs of them having been disturbed so efficient had been the work of the resurrectionist. Further search, however, revealed



**WHEN THE BABY HAS COLIC "...AND
SCREAMS**

**WITH THE OUTRAGED VIGOR OF A
WOUNDED TIGER AND PUNCTUATES
HIS SHRIEKS WITH FLATUS..."***

Skopyl[®]
Methyl Scopolamine Nitrate

FOR THE TREATMENT OF INFANT COLIC

Easy Administration: Just one or two drops of Skopyl under the tongue, 20-30 minutes before each feeding — or 3 drops for an acute attack of colic.

Fast Action: The rapid absorption of Skopyl into the blood stream via the oral or sublingual route often gives immediate and dramatic relief of acute abdominal pain characteristic of infant colic.

Action and Safety: The main effect of Skopyl is peripheral. It has a particularly depressant effect on the tonus and motility of smooth musculature of the gastrointestinal tract. Because of Skopyl's high degree of selective action and favorable therapeutic index, the recommended small volume dose can generally be given with a minimum incidence of side effects.

*Editorial: New England J. Med. 260:246 (Jan. 29) 1959

Precautions: Fluid balance should be restored in dehydrated infants or those with oliguria before beginning treatment with Skopyl.
Indications: Colic (paroxysmal fussing, infantile dyspepsia, irritable crying), infantile vomiting, infantile diarrhea, pyloric spasm.
Available: 5 cc. dropper bottle. One drop=0.6 mg.; 40 drops=1 cc. Pharmacia Laboratories, Inc., 501 Fifth Avenue, New York 17, N.Y.

that the earth had been carefully removed some distance from the head of the graves. When the sexton dug down to the head of the caskets he found the ends had been removed by means of auger holes bored through them. Evidently the bodies had been pulled through the open ends of the caskets by means of a hook inserted under the chin, since the marks of a sharp instrument appeared on the necks of the victims.

These startling events, which occurred on the morning of Nov. 14, 1878, immediately set off a chain reaction that provided the local newspapers and their readers with sensational accounts for several weeks thereafter. The editorial comments were written with vitriolic vengeance on medical colleges and the procurers of their anatomical material. Thus, the editor of the *Zanesville Daily Courier*, Nov. 14, 1878, commented that "Popular indignation is aroused everywhere against the system of procuring material for the dissecting table, which makes the lifeless remains of our dearest friends articles of common merchandise.

"The widespread discussion through the newspapers, in the pulpit, on the streets and at the fireside, which followed the revolting revelations of the horrors met with in the dead rooms of many of the medical colleges of the land, seems only to have had the effect to make the ghoulish resurrectionists more determined but at the same time more cautious. The business of procuring material at first, as is popularly supposed, was confined to the larger cities, but now in the light of recent developments we are forced to the conclusion that the Potter's fields and unmarked graves in the cemeteries no longer yield a sufficient supply of 'stifs' for the students' knife, in the interest of science.

"Public indignation has arisen to a white heat at these terrible crimes, and scarcely a day passes that the sickening details of a case of body snatching are not flashed over the wires, and the readers of daily journals nauseated afresh at the mention of another monstrous outrage. The citizens of Zanesville have congratulated themselves all along that the graves of our dead have escaped the ruthless hand of the modern monstrosity—the resurrectionist—but in our fancied security lay our greatest weakness. Remote from a medical college, no danger was anticipated. Alas! the arts of the body snatchers were not well understood, and the citizens of Zanesville today stand aghast at the most terrible crime in local annals."

A Surprising Disclosure

To return to the fate of the stranger who eluded his pursuers at Brownsville by escaping into the

woods, the news of the episode spread like wild-fire through the countryside and in a short time a large crowd of men gathered at the toll-gate in response to the call sent out by the gate-keeper. The posse made a thorough search, without any success, however, as no trace of the hunted stranger could be found. Whatever the man's identity might be, it was held with certainty that he had resurrected the bodies for disposal to one of the medical colleges in Columbus. Accordingly that afternoon a Zanesville police officer boarded a train for Columbus where he hoped he might be able to obtain information relative to the identification of the resurrectionist.

It so happened that the Marshal of Newark boarded the train there for Columbus on business and the two officers who were acquainted were soon engaged in conversation over the visitation of the graveyard ghoul at Zanesville. When the train stopped at the village of Outville, about 15 miles east of Columbus, it picked up a passenger whose appearance soon aroused the officers' suspicions, as it tallied with the description furnished by the night patrolman. In addition, the stranger looked as though he had walked across country on foot, since his clothing and shoes were besmeared with mud and he was covered with Spanish needles. The police officer being quick to sum up this tell-tale evidence placed the man under arrest on suspicion of grave robbery.

Upon the arrival of the trio at the Union Station in Columbus the prisoner was put in the city jail pending the departure of the next train for Zanesville that evening. Under questioning he gave his name as L. S. Eaton and confessed to the charge. He also implicated two confederates, one of whom was a Columbus physician and the other, a young man who was employed as a clerk in a Columbus department store. He also disclosed that the horse and vehicle he used had been hired for him by the doctor from Russell's livery stable in Columbus; that he lived on Buttles Avenue and worked as a carpenter at Peter's Buggy Company during the daytime. He confessed he had been resurrecting bodies for the medical colleges in Columbus at night for the past three years.

Eaton was returned to Zanesville on the evening train. An immense crowd was gathered at the depot and threatened to lynch the prisoner. But the escorting officer fearing such a movement eluded the crowd by taking Eaton off the train a few blocks from the station and escorting him through an alley to the police station where he was booked on the charge of unlawfully opening four graves in a local cemetery.

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Doctor, What's Wrong with My Baby?

WENDELL A. BUTCHER, M. D.

HOW OFTEN, doctor, have you faced, unarmed with adequate information, a family that included a mentally retarded member? Moreover, you are probably not the first physician to be so confronted by the family. Experience indicates that most of these families have already "shopped around" the medical profession, including specialists, often receiving opposing advice and counsel.

It is not at all surprising that you should feel inadequately informed on this subject, which can and has caused so much grief, pain and misunderstanding in some of your families. A great deal of confusion, unfortunately, continues to exist even among those most interested in the subject of mental retardation. Since it occurs in a relatively large proportion of our general population—2.5 to 3 per cent—it behooves us as physicians at least to be aware of those recent developments in this field as may be available to us.

It is the purpose of this paper to discuss generally the field of mental retardation and/or mental deficiency (terms often used interchangeably), with particular reference to the existing situation in Ohio. Even at the outset, we find that the terms we learned in medical school are no longer acceptable. The term feeble-minded has no acceptance with the family of a retardate. The words moron, imbecile, and idiot are also in disrepute. The American Association on Mental Deficiency, a professional organization, and the National Association for Retarded Children, a nationwide well-organized group of laymen, made up largely of parents, both recommend the use of the terms educable, trainable and dependent, respectively, as being more useful and much more

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acceptable. In fact, the terms mentally retarded, mentally deficient and feeble-minded are not in themselves diagnostic terms, but merely descriptive terms and should be used only in that sense.

In former years the intelligence quotient, as measured by the Stanford-Binet or some other standard psychological test, was used to establish retardation and its degree. This is indeed unfortunate, since such tests are no more diagnostic than the blood cell count is diagnostic of acute appendicitis. Psychological testing, although of great assistance in aiding the physician in making a diagnosis of retardation and in mapping out a program for a retarded person, should be recognized as being a laboratory procedure. In addition, it is recognized that an IQ level obtained at one time may vary as much as 10 points from that obtained at another time, particularly when the retarded person is under emotional strain.

Complete Diagnostic Facilities Are Available

The physician is often confronted with the problem of assisting parents in obtaining an evaluation of a retarded child, without knowing where to

obtain the services of a psychologist and/or a social worker. Both of these, if experienced in this field, can be of great assistance. Presently, the State provides two clinics where such services are available at no cost to the parents: the Clinic for Mentally Retarded, 1601 West Broad Street, Columbus 16, Ohio; and the Hamilton County Diagnostic Clinic for the Mentally Retarded, 295 Erkenbrecher Avenue, Cincinnati 29, Ohio. These clinics, which prefer to operate on referral from private physicians, may be contacted by letter. Such letter should request an appointment date and should contain both the family's name and address, and that of the referring physician.

The clinics are unable to provide lodging and/or meals during the examination period, which lasts at least one day. Therefore, relatives should be prepared to provide for these themselves. The clinics will expect the relatives to present as extensive a social and medical history as possible. If requested by the referring physician, the information obtained at this evaluation will be forwarded to him. However, it should not be expected that these clinics will advise the parents what they should do with the retarded child.

If the family is unable to go to either of these clinics, less complete assistance can usually be obtained from local sources. Information regarding other sources can usually be obtained either from the local County Association for Retarded Children or from the County Child Welfare Board.

In the past some physicians have taken rather dogmatic positions in advising relatives as to the disposition of retarded persons in the family. Some have maintained that all retarded children should be retained in the home as long as possible. Others at the opposite pole have recommended that all children or adults should be institutionalized as soon as the disease or condition is recognized. Both such divergent viewpoints certainly require close examination.

Every patient presented for our consideration, whether mentally retarded, or the victim of any other disease process, certainly deserves individual consideration as a person and should not be the subject of a predetermined treatment schedule before all aspects of the condition have been considered. After having obtained adequate professional information on the problem at hand, the physician and family must consider the answers to three basic questions in order to make an intelligent decision. I cannot emphasize too much the need for the family to be a part of this discussion. These questions are as follows: (a) What will be the effect of retention in the home on the retarded child? (b) What will be the

effect on the other members of the family of such retention? (c) What will be the effect on the community of such retention?

Schools, Private and Public

Obviously, at least a part of the answer to these questions must be based upon the facilities available in the immediate community, and elsewhere, to assist the responsible relative. If consideration leans toward retention of the child in the home, there are frequently many community activities available for helping the relatives. The local County Association for Retarded Children will assist in determining exactly which facilities are available in the community. Children having multiple handicaps in addition to their retardation, such as blindness, cerebral palsy, etc., are special cases and in some areas are provided special assistance through the Child Welfare Board.

Under Ohio's present public school laws, *permissive* legislation allows each school district to establish "special or slow learner" classes for educable (roughly IQ's above 50) children up to the age of 18 years. The local county or city school superintendent's office has information as to whether these facilities exist, or can be established, in the community. It should be noted that experience has shown that roughly 75 per cent of retardates in this educable group can be educated and/or trained to become self-supporting during their adult years. The objectives of these special or slow learner classes in the public schools are those of teaching self-regulation, acceptable human relationships, economic efficiency and civic responsibility.

In the area of the trainable child, (IQ's under 50), sometimes classified by educators as severely retarded, classes for children up to the chronological age of 18 have been established in Ohio's communities. This program, under the auspices of the Department of Mental Hygiene and Correction, has had tremendous growth in Ohio and now includes over 2,500 mentally retarded children. These classes are operated through the County Child Welfare Boards and are sponsored at the community level by the County Association for Retarded Children. Information concerning them may be obtained locally from these individual organizations. They accept children who have been legally excluded from the public schools by the local superintendent and the State Department of Education and who are able to benefit from group experiences. In addition, certain of the councils for retarded children have established sheltered workshops for adult retardates where simple profit-making jobs are performed for local industry on a contract basis. These workshops provide some

income for the retarded persons working there and allow them to be useful citizens.

Costs of Private Care Versus Commitment

If the consideration leans toward institutionalization of the child, there are two avenues of approach available, that of private schools or homes or of State-supported schools or institutions. Private institutions, of course, are operated as a means of livelihood for the operators, or as charitable institutions usually by religious orders. There is tremendous variation in cost to the family among such institutions, depending on what they offer. This cost varies roughly from \$100 to \$600 per month with extras for clothing, special medical care, etc., often added.

A listing of these institutions, together with their addresses and rates, may be obtained from two sources: (a) Listing of State and Private Training Schools and Homes for the Retarded, American Association on Mental Deficiency, P. O. Box 96, Williamantic, Connecticut, cost \$1.00 and (b) Directory for Exceptional Children, Porter-Sargent, Publisher, 11 Beacon Street, Boston 8, Massachusetts. These are brought up to date every two years, and the mere listing of the institution does not indicate approval of its facilities or staffing by the listing organization. Parents, themselves, should visit the institution of their choice as each such institution presents a different program and has different rules and operating procedures.

If the responsible relatives feel that institutionalizing at a private school or home is not feasible, they may arrange for care of the child at a State-supported institution. In this event, present Ohio law requires that the person be legally committed, by the probate court of the county of legal residence, to the State of Ohio. When the responsible relative has made application to the probate judge or his clerk for commitment, a physician must certify to the judge that the person is, in his opinion, mentally retarded.

After the commitment procedures have been completed, the retarded person is placed on the waiting list of the individual county for conveyance to the Diagnostic and Receiving Center for the Mentally Retarded, located at Columbus State School. Unfortunately, the limited number of beds in the State system necessitates a waiting list in each county. The State Department of Mental Hygiene and Correction has set up a quota system for each county based on that county's population and has arranged for an orderly rate of admission based on that quota. It should be pointed out that each individual probate judge has the preroga-

tive of determining the priority of admission within his quota.

They Are Not "Put Away"

Physicians will be interested to know that the Diagnostic and Receiving Center provides a very complete and extensive diagnostic service after admission of the committed person, including such things as electroencephalograms, pneumoencephalograms, consultation by board members in the various specialties, complete psychological and social service evaluation, etc., when indicated. The total evaluation requires two to three months. The retarded person is then transferred to one of four institutions: Columbus State School proper; Orient State Institute, located approximately 20 miles southwest of Columbus; Gallipolis State Institute at Gallipolis, Ohio; or Apple Creek State Hospital, near Wooster. Transfers are made mainly on the basis of bed availability and geographic location of the county of the retardate's origin.

Under another section of the Ohio Code, responsible relatives of a committed person are required, *if able*, to pay a sum equal to the cost of his maintenance, to the State. This amount is recomputed every two years on the basis of the cost per patient during the previous biennium.

It is unfortunate that many parents find "commitment" a frightening word. Actually, it is no more than the legal process by which, after conveyance, the State assumes legal guardianship of a person. In the case of the retarded, commitment can be dissolved by the medical superintendent of the institution in which the person is residing, providing he feels it is in the best interest of the retardate. In addition, the superintendent may grant the person extended trial visits to his home if the parents wish and if they agree to assume responsibility for the person during the visit. When on extended trial visit, the retarded person may be returned to the institution at any time without going through re-commitment. However, after a complete discharge, he must be re-committed in order to return to a State institution. In general, superintendents are very lenient in granting vacations, extended trial visits, and discharges whenever they are in the best interests of the committed retardate.

New Horizons

A word as to what can be expected in terms of end results of an adequate training program. The *educable* retardate can assimilate up to a fourth or fifth grade education. He can be adequately trained in a number of vocational skills, such as farm hand, janitorial work, painter's helper, less complicated areas of food service, or nurse's

aide, and may be able to make a very positive contribution to our economy. More important in his training is the giving of adequate job habits and providing adequate social skills for good citizenship. To a lesser degree, this is possible for approximately half of the *trainable* retardates. However, the trainable retardate must be in a much more structured situation in his community living situation and he requires a longer time in reaching the goals outlined.

Since mental retardation is presently the subject of much renewed interest, research in the field is growing rapidly. Prevention rather than cure is, of course, the goal of this field. Evidence points out that the first trimester of the pregnancy is the critical time in the development of the human nervous system. While the role of the measles virus as a causative agent of mental retardation during this period has perhaps been slightly over-emphasized, it is undoubtedly of importance. The role of other viral diseases, inadequate diets for mothers during early pregnancy, the effect of various drugs, etc., during this period are being investigated. It is probable that these and other factors play a very important causative role in many cases presently diagnosed as idiopathic. Various research centers throughout the country are presently investigating these problems and physicians should be on the alert for specific new discoveries. One of the more important recent developments is a simple urine laboratory test to detect in the newborn the presence of phenylketonuria, a rare cause of severe mental retardation and the discovery of the means of preventing this type of mental deficiency.

In summary, there are three outstanding phases of the program for mentally retarded in Ohio with which the physician should be familiar. First, the rapidly expanding community and State-supported classes for the trainable child remaining at home. Second, the institutional program, including academic and vocational training presently available for educable retardates at Columbus State School. Third, the diagnostic facilities available to both newly committed retardates and to outpatients in the two clinics supported by the Department of Mental Hygiene and Correction.

Diagnosis of Aortic Stenosis In Doubtful Cases

By reliance on the "classical" findings of aortic stenosis the diagnosis will be missed about 50 per cent of the time. . . . In doubtful cases and those in whom surgery is contemplated, cardiac catheterization should be carried out.—Donald C. Edgren, M. D., Rockford, Ill.: *Illinois M. J.*, 115:137, March, 1959.

Medical and Surgical Treatment of Segmental Ulcerative Colitis

Segmental ulcerative colitis has been defined to include only that type of colitis that is limited to a segment or a portion of the colon with no involvement of the terminal ileum or the rectum. . . . Our incidence of patients with segmental colitis, as compared to the incidence of patients with all types of ulcerative colitis, is approximately one per cent.

Of nine patients, seven were treated medically. Four of these made satisfactory progress, while in three the disease progressed and required surgery.

Five patients underwent surgery and good results were achieved in all, although some patients required more than one operation. Two of three patients in whom segmental resections of the involved areas were done had no recurrence of colitis in four and five years.

We believe that medical treatment should be given initially. If the disease fails to respond to adequate medical therapy and/or there is progression of the disease, surgical treatment is indicated.

Surgical treatment should remove completely the diseased tissue, but at the first operation preservation of normal bowel (i. e. segmental resection) is advisable. If there is incapacitating recurrence, subtotal colectomy with ileoproctostomy or total colectomy with end-ileostomy may be done subsequently.—Edward J. Kurt, M. D., Toledo, and Charles H. Brown, M. D., Cleveland; *Am. J. Gastroenterology*, 31:419, April, 1959.

Care of Premature Babies 20 Years Ago and Now

Fashion has decreed a new look in the care of the premature baby. . . . To do the exact opposite in every detail of what was done to premature babies twenty years ago is a safe rule for the modern pediatrician.

This curious reversal of old-fashioned practice, . . . has involved the care of the umbilical cord. Boracic powders date from the Listerian 'seventies, but binders from antiquity. About a decade ago binders went out of fashion, the whole cut cord was painted with collodion, then only the cut end was so painted and finally the cord was left unpainted and undressed. The experiment illustrated the general proposition that with normal babies any treatment succeeds unless and until it is put to the test. Experience eventually teaches the dangers of infection of the cord and leads to some protective treatment.—A. W. Franklin: *Practitioner*, 182:79, January, 1959.

Poison Ivy Prophylaxis: Folklore or Scientific Medicine?

WILLIAM F. MITCHELL, M.D.

POISON IVY (*Rhus toxicodendron*) is the main cause of plant dermatitis in this country. The irritating oleoresin is present in the leaves, stems, seeds and roots and can be extracted with ethyl alcohol and other solvents.

Poison oak is the same plant, or a closely related plant, which grows in the Western states. Its leaves have some resemblance to small oak leaves. The irritating chemical is identical in poison ivy, poison oak and poison sumac. Closely related chemicals, all catechols, are the irritants in the oil from the Japanese lac tree, cashew nut shell, the rind of the mango (the oriental fruit) and the Indian ink tree.

Since Shamberg¹ in 1919 reported good protection against poison ivy (*Rhus*) dermatitis following ingestion of a weak tincture of its leaf there have been many favorable as well as inconclusive reports which have been reviewed recently by Stevens² and Kligman.³ For 18 years the author has used extracts of poison ivy leaves, orally, for prophylaxis against dermatitis from the plant. Results, with alcoholic extract have been predominantly favorable. However some patients complained that this extract was inconvenient and distasteful. To overcome these objections the plant oleoresin was incorporated in gelatin capsules.

Description of Oleoresin Capsules

Fresh dried crushed poison ivy leaves were extracted at room temperature with absolute aldehyde-free ethanol and then filtered. The stock extract was adjusted to contain 500 mg. of non-volatile solids (crude oleoresins) per 100 ml, added to inert filler, and placed in No. 3 gelatin capsules. For this investigation, each 50 unit capsule contained 250 micrograms oleoresin; 10 unit capsule, 50 mcg.

Patch Test for Poison Ivy Sensitivity

The procedure employed was as follows: 0.05 ml. volumes of serial dilutions of the stock extract were placed on standard white blotting paper squares, each 0.5 sq. cm. in area. After drying for five minutes, the squares were applied with adhesive or plastic tape to the back or medial aspect of the arm for 12 hours, or less if itching was intense. The site was observed in 48 to 72 hours.

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A positive reaction consisted of papules, macules, or vesicles at the test site.

In one typical experiment, an extract was titred by this technique on 20 individuals. The minimum amount, in micrograms, eliciting a positive response averaged 1.5 with a range of 0.5 to 12.5. Because of this expected wide variation in biological response, one poison ivy unit is defined as equivalent to 5 mcg. of crude non-volatile residue (oleoresins) obtained from an extract as previously described.

Clinical Results

Patients were selected as follows: Group A consisted of 54 children and adults with a history of repeated dermatitis in summer and a positive reaction to patch test with dilute alcoholic extract of poison ivy leaf. Group B consisted of 39 men who maintain rural power lines in Central and Southern Ohio, and whose personnel records show that they have lost working time and/or required treatment because of poison ivy dermatitis.

Patients who gave strong skin reactions to patch tests with less than 6 mcg. crude oleoresin were started on one 10-unit capsule daily for one week. The second week they received 20 units daily. Thereafter they received one 50-unit capsule daily until September 1. Less sensitive patients, as determined by patch tests, were advised to take 50 units daily from the beginning. Some received 100 units daily after the first month. Each patient took between 5,000 and 10,000 units during the poison ivy season. The prophylactic treatment was started in March or as soon thereafter as possible. Some did not start until July after having suffered one or more bouts of weed dermatitis in the preceding four months.

All patients were advised to pursue their usual summer activities but to avoid deliberate contact

with poison ivy. At the end of the 1958 season most stated that they had acted in accordance with this advice but several had unusually heavy exposures.

Of the 93 patients who ingested 5000 or more units of the poison ivy oleoresin in capsules, 84 were satisfactorily protected according to the following criteria; any case wherein the patient required medical treatment or lost time at work because of a rash which was supposedly or definitely due to contact with vegetation, the result was considered unsatisfactory.

Included among the nine failures were three power-line workers. Two of these three had previously lost many days of work each summer because of ivy dermatitis. Though classed as failures according to our criteria these two men were personally satisfied with their results because they were not incapacitated by the rash in the 1958 season. The remaining six failures included four children and two women. It is notable that the dermatitis in three of the four children occurred at the end of the summer and in early autumn after a season of the usual exposure without developing a rash. One of the women developed dermatitis only in those areas contacted by her husband's hands after he cleared a fence of poison ivy during the day.

The only undesirable reactions which might have been produced by the treatment were six instances of mild dermatitis, which disappeared when the oleoresin capsules were stopped but did not return when the capsules were resumed. There was no irritation of the oral mucosa or the anal region in any case. The author who is mildly sensitive to the plant, and an associate who is moderately sensitive to it ingested 10 times the usual dose, (i. e. 500 units daily) for 10 days with no discernible reactions.

In order to test its stability, an alcoholic extract of the encapsulated oleoresin-powder mixture was made at the time of preparation and at intervals throughout the subsequent year. According to measurements by serial patch tests on several sensitive individuals and by spectrophotometry, 65 per cent of the original oleoresin was recovered from both the fresh and the year-old capsules, which had been stored at room temperature, protected from light and air.

Discussion

In spite of numerous favorable reports^{2, 4, 5, 7} the prophylactic value of *Rhus* extracts against dermatitis from contact with the plant may not be established until it can be tested on large groups of sensitive individuals with adequate controls.

Stevens² emphasizes this fact in his review and report to the American Medical Association Council on Pharmacy and Chemistry after stating that, "There appears to be no unfavorable report on this method of prophylactic treatment." The protection attained by this method is temporary.^{3, 6}

Reports of toxic reactions to ingestion of parts of the plant or extracts thereof involve instances of massive overdoses, or eating large amounts of raw plant. Reported reactions following recommended doses of alcoholic extracts of poison ivy include only mild to moderate dermatitis which disappears within a few days after the extract is discontinued. In such cases the average doses can usually be resumed without trouble. Pruritis ani⁴ tends to occur temporarily when the oleoresin is ingested in a vegetable oil vehicle.

Shelmire⁵ and Kligman⁶ have demonstrated reduction of skin sensitivity after prophylactic treatment by patch tests with serial dilutions of the alcoholic extract. Of seven patients included in the current study where pre- and post-treatment patch tests were completed, six showed a decrease in skin sensitivity and one showed an increase.

Summary

1. The alcohol soluble fraction (oleoresin) of the poison ivy leaf was incorporated into gelatin capsules with inert powder filler, and administered to sensitive patients for prophylaxis against poison ivy dermatitis.

2. Of 93 patients so treated, who would be expected to develop some dermatitis from exposure to poison ivy in the past summer, 85 (or 91 per cent) were adequately protected.

3. Patch tests and spectrophotometry indicated that the oleoresin in capsules, prepared as described in the foregoing, maintained its potency for a year.

Acknowledgment: The author wishes to thank Dr. George Y. Shinowara, Professor, Department of Pathology, Ohio State University, for his helpful suggestions and his cooperation in completing gravimetric, spectrophotometric and other determinations used in control of the extract.

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Serum Sickness — Allergic Reactions to Piperazine

A Report of Three Cases

AARON J. FINE, M. D., and LEWIS E. ABRAM, M. D.

WE have recently seen three patients with allergic reactions who have been on piperazine in an attempt to eradicate *Enterobius vermicularis* (pinworm) infestation. We decided to report these cases because two of them exhibited serum sickness type reactions which have heretofore not been ascribed to piperazine.

Alexander,¹ in his book, *Reactions with Drug Therapy*, considers "serum sickness pattern" an appropriate term to apply to serum disease that is caused by drugs. Urticaria, arthralgia fever and lymphadenopathy are the most common signs and symptoms associated with the "serum sickness pattern."

In 1955, Ratner & Flynn² evaluated the allergenic properties of piperazine in guinea pigs. They were unable to produce anaphylaxis in the experimental animal and concluded "that this drug should be regarded as a nonallergic drug." Piperazine has been used extensively because of its effectiveness and low incidence of toxicity. Bumbalo and Plummer³ reported treating 500 patients with intestinal infestations with piperazine. In their series, they encountered only one case of urticaria.

Rachelson and Ferguson⁴ similarly treated 150 patients, with the occurrence of side reactions in only seven—an incidence of 4.6 per cent. Four of these seven patients experienced urticaria. Of these four, three were on a second course of therapy and all had the urticaria after completion of their second course with piperazine. Hill⁵ treated 194 children with no report of any allergic reactions.

Report of Three Cases

The clinical histories of our cases are as follows:

Family "A" consisted of four members, who were receiving their second course of piperazine therapy. The first course of treatment, which lasted seven days, antedated the second by two months.

The mother in family "A" had been taking 2000 mg. piperazine each day until the fifth day when she developed urticaria. This temporarily cleared with epinephrine 1-1000 solution hypodermically and an antihistamine by mouth. During the night, she had a recurrence of urticaria and when seen in our office the following morning, she had generalized giant urticaria. At this time, she was given subcutaneous epinephrine 1-1000 solution with moderately good results. Before leaving the office she also received 40 units ACTH gel intramuscularly and was instructed to take Pyribenzamine® 50 mg. every four hours while awake.

That evening, the urticaria recurred and in addition, she began complaining about pains in her ankles, knees and left wrist which appeared to be swollen. Steroid therapy was instituted with 10 mg. prednisolone three times a day. Within 24 hours, she had virtually com-

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plete remission of her symptoms. Steroid medication was continued in gradually decreasing doses for the next six days and the patient had no recurrence of symptoms when they were discontinued.

Family "B" also consisted of four members, who were taking a repeat course of piperazine for control of pinworm infestation. Their previous course of therapy was given approximately six to eight months earlier. The entire family was treated for seven days with a seven day free interval and then a repeat course of treatment for seven days.

There were no adverse reactions during the first seven day course of therapy. However, two days after the second course of treatment was started, the father had mild urticaria lasting 36 hours. It was controlled with antihistamines and discontinuation of the drug.

Two days following the completion of therapy, the five year old boy in family "B," who had been receiving 500 mg. piperazine twice a day, began complaining of pains in his ankles. Within 12 hours, he had bilateral swelling of his ankles and knees with warmth and tenderness. There were superficial areas of erythema around these joints. At this time, his rectal temperature was 100.4 degrees F. He was started on Benadryl,® 25 mgm. four times a day and within 24 to 36 hours his symptoms completely subsided.

Discussion

Clinically, two of our patients had signs and symptoms that are consistent with drug induced serum sickness reactions. Of importance in this regard is the fact that both of these patients had used piperazine before and the reactions occurred upon their subsequent use. In both cases, the symptoms were easily controlled with antihistamines and/or steroids, and they were both acute illnesses of short duration.

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The Dietary Management of Diabetes

JOSEPH I. GOODMAN, M.D.

THE composition of the diets used in the management of patients with diabetes has undergone marked change in the past 50 years. Before the introduction of insulin it had been demonstrated that glycosuria and even ketosis could be controlled to some extent by the induction of undernutrition. At that time, the use of undernutrition as a lifesaving measure was fully justified. Obviously, a malnourished living patient was preferable to a well fed dead one. An accurate, low caloric regimen necessitated that food be weighed or measured.

The anxieties associated with the early use of insulin overshadowed the benefits of low caloric diets. Moreover, the attention of the physician was so sharply focused on the chemical control of the diabetes that frequently he lost track of the content of the diet and his patient's overall nutritional state. As time went on and experience and confidence was gained in the use of insulin, larger and larger quantities of food were permitted. The basic concept of undernutrition still prevailed however. Besides, it is easier to regulate glycosuria with limited food intakes than with expanded diets. Inevitably the diets of diabetic patients eventually increased to virtually the same caloric levels as those of non-diabetics.

It should be kept in mind that diet, based upon the patient's nutritional needs, is still fundamental in the treatment of diabetes. It has been estimated that perhaps 50 per cent of all diabetic patients can be managed by the use of diet alone. The choice of diet is dependent primarily upon the patient's *weight*. A primary objective of effective diabetic therapy is the attainment of an ideal body weight which can be estimated from the Metropolitan Life Insurance Company tables.

Almost all obese diabetic patients can be regulated by means of diet alone, provided ketosis is slight in degree or absent. The use of insulin in these patients tends to enhance the obesity, without a guarantee that effective regulation will be achieved thereby. In fact, one frequently observes in such cases increasing dosage of insulin over successive months and years. Even the thin diabetic can get along very well for a few days at least merely with dietary regulation. John¹ takes the opposite point of view, namely, that it is

¹This is the second in a series of four articles prepared by the author, dealing with the Management of Diabetes, the first having been published in the November, 1958, issue of *The Ohio State Medical Journal*.

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preferable to prescribe insulin for an obese diabetic rather than gamble on the control of the diabetes by means of a time-consuming, low caloric diet and the great effort attendant thereto.

The diabetic patient who has become underweight as a result of unregulated diabetes, previous drastic dietary restriction or whatever cause should be provided with a high caloric diet in order to reestablish a normal nutritional status as rapidly as possible. Having attained the normal weight in such a patient the diet is gradually decreased in calories to one that will just maintain his proper weight.

Provision of Adequate Nutrition

It is axiomatic that good health is dependent on optimum nutrition. Normal growth and development as well require an adequate nutritional intake. In order for an individual to be able to carry out his daily work and have a sense of well-being, the food intake must assure an adequate supply of nutrients from calories to trace elements.

The caloric content of a diet prescribed for the diabetic should represent similar requirements necessary to maintain body weight, rate of growth, and physical activity of fully healthy individuals over long periods of time. The diet prescribed for a diabetic child, for example, should not differ to any great extent from the normal diet of children of similar age. Therefore, a child with diabetes now receives an adequate intake of calories, proteins, vitamins, and minerals to insure normal physical development and to supply energy for normal play. The same principle applies to the working man who requires sufficient fuel to enable him to work efficiently at his job.

Calories

As mentioned in the foregoing, the caloric requirement of the diabetic's diet may be ascertained by consulting the Metropolitan tables for the patient's ideal weight. My plea and my practice is to

TABLE 1.—Reprinted with permission of Dr. Alan S. Cohen and the Boston Medical Quarterly from article entitled: "Juvenile Diabetes: Onset and Management of 12 Recently Discovered Cases," Boston Medical Quarterly, Vol. 7, No. 4, December, 1956.

GUIDE FOR PRESCRIBING DIETS FOR DIABETIC CHILDREN* RECOMMENDED DAILY CALORIE ALLOWANCES							
Infants	Calories	Children	Calories	Boys	Calories	Girls	Calories
1 - 3 Mos.	120/Kg.	1 - 3 Yr.	1200	10 - 12 Yr.	2500	10 - 12 Yr.	2300
4 - 9 Mos.	110/Kg.	4 - 6 Yr.	1600	13 - 15 Yr.	3200	13 - 15 Yr.	2500
10 Mos. - 1 Yr.	100/Kg.	7 - 9 Yr.	2000	16 - 20 Yr.	3800	16 - 20 Yr.	2400

*Recommended Daily Dietary Allowance, 1954, Food and Nutrition Board, National Research Council

teach patients to eat the same quantity of food as non-diabetics of the same age and sex categories. In most texts I believe the figures on dietary requirements for health are far in excess of actual needs. The average food intake of young men and women of normal weight rarely exceeds 2,100 calories.

The diets for diabetics should be calculated with such normal figures in mind. *The prime requisite of the body is for calories.* With respect to the vitamins and trace minerals, it can be said that the diets prescribed for diabetics, with the accent on fruits and vegetables, usually contain sufficient amounts of these protective elements. *The administration of vitamins in large surplus will not prevent death from starvation if the caloric intake is inadequate.* To date, there is no substantiated evidence that the diabetic population suffers from general vitamin deficiencies.

Elaborate formulas have been prescribed in the past for diabetic children but the present trend is toward a diet which parallels that of the normal child—sufficiently varied to avoid monotony and adequate for normal growth. In calculating the calorie requirements for infants, the pediatrician usually allows between 100 and 120 calories per kilogram of body weight during the first year. The height standard provides 35 calories per inch. The weight standard provides 50 calories per pound at age one, 35 calories at age five, 30 calories at age 10, and 25 calories at age 15. The age standard furnishes 1,000 calories at one year of age with an additional 100 calories for each succeeding year of age through adolescence (age 13 for girls, age 19 for boys).

The use of these standards will yield comparable estimates of the caloric needs for the average child (Table 1). One should make allowances, however, in the individual case for undernutrition, obesity, and unusual physical activity. Recent experimental evidence indicates that boys have greater requirement than girls by virtue of their more active play periods.

Changes in the patient's body weight are better guideposts than any arbitrary table as to whether the food intake is too high, too low, or just right.

The aim of course is to control diabetes, to maintain normal weight, and to do this by providing a palatable, well balanced, easily followed, and easily understood diet.

Composition and Calculation of the Diet

Experience in the office, hospital, home, and particularly in camps for diabetic children, has taught us that not only does a carefully regulated diet simplify regulation of diabetes, but also that on such a food regimen the boy or girl can be happy, contented, and psychologically well adjusted. We do not require that the food be weighed; with rare exceptions, regulation of the diabetes can be achieved as readily with the exchange system as with a weighed diet. Moreover, the average patient rebels at micro-measured dietary schedules.

Nevertheless, since food intake is an important factor in diabetic control, a quantitative diet makes it possible to maintain this factor relatively constant. Satisfactory results can be achieved by using ordinary household measures. A measured diet gives parents and children a knowledge and understanding of food values. It prepares children to make intelligent dietary choices during adult life when it is neither possible nor desirable to have all meals planned and prepared in the home.

An adequate diet which approximates the food of the whole family does not impose the feelings of discipline and deprivation which were so common when starvation or other limited diets were accepted methods of treatment. A variety of food choices is possible and encouraged. Substitute meals can be calculated for school and picnic lunches as well as for children's parties.

Since diabetes involves more systems than carbohydrate metabolism alone, equal attention should be given the other constituents of the diet. For the adult one gram of protein per kilogram of ideal body weight is customarily given. Fat is used to complete the caloric requirement. The following are the essentials of a well planned diet for children with diabetes: (a) adequate amounts of protein, minerals, vitamins, and calories; (b)

interval feedings, adjusted to the type of insulin being used; and (c) reasonable constancy of dietary pattern from day to day. The average normal child usually consumes about 50 per cent of his calories as carbohydrates, 15 per cent as protein, and 35 per cent as fat. The diabetic's diet may be similarly distributed, or somewhat more protein may be allowed at the expense of carbohydrate and fat.

Thus it is possible to provide the diabetic with a well balanced, easily obtained, palatable diet which might well serve as an example to everyone instead of the luxury diet in which most of us indulge ourselves. Those who believe in uniformity of diet from day to day encounter a majority of cooperative patients and a few who do as they please. It is poor psychology for physicians to stress to the diabetic patient only the items of food to be avoided. It is preferable to lay emphasis upon those foods which are permissible so that he is not frustrated right from the start. In this manner, he is not likely to develop the feeling that his diet is a radical departure from the family menu, that he is "set apart," so to speak, from the rest of mankind. The use of special foods, such as gluten bread and diabetic desserts, is not advised.

Curative Effect of Fat-Free Diet in Diabetes Mellitus

The author is convinced that the striking results which can be achieved with low fat diets has never been reflected adequately because the conventional "aggressive" use of insulin, prescribed concurrently, hopelessly confuses the picture. I feel that the true indication for insulin in a diabetic cannot be gauged until the liver is freed of excess fat and replenished with glycogen, a condition indispensable to normal carbohydrate metabolism. Because of the high proportion of overweight diabetics who should be reduced to normal levels, there is an added reason to prescribe low fat diets. Weight reduction automatically implies a subcaloric diet for varying periods, which of course necessitates reduction of fat to a minimum, so long as one insists on lipotropic carbohydrate and protein rations as a *sine qua non*.

By simply withdrawing fat alone, without a change in the dose of insulin and without a change in the carbohydrate content, the blood sugar level and the glycosuria are reduced within one or two days. Patients do not experience hunger or any other subjective discomfort on this regimen. The beneficial effect of fat-free and fat-restricted diets occurs in newly discovered patients with diabetes mellitus, in those with diabetes of one to nine years' duration, and in those with diabetes of 10 or more years' duration.

The favorable effect of the low fat diet may be observed in both male and female patients. Wolf and Priess² reported 10 patients in whom azotemia subsided within two days after the institution of such a diet. They also reported improvement in eight patients who had gangrene of the lower extremities. Continuous treatment with a fat-free diet is inadvisable because of the need for unsaturated fatty acids and fat-soluble vitamins.

The Food Exchange System

The diet prescription is worked into a meal plan for the day by use of the exchange system devised jointly by the American Diabetes Association, American Dietetic Association and the Diabetes Unit, United Public Health Service. This diet system presents six basic meal plans varying from 1200 to 2600 calories with carbohydrate content varying from 125 to 250 grams, protein from 60 to 100 grams, and fat from 50 to 130 grams. The diets contain a ratio of two grams of carbohydrate, one gram of fat, one gram of protein. The amounts allowed of each of the food groups is also listed at various caloric levels. For a child's diet, the caloric needs are estimated and a diet list for that number of calories used.

The common foods allowed the diabetic are divided into six groups within each of which foods may be exchanged. They are as follows:

- | | |
|---|----------------------|
| 1. Milk | See List I |
| 2. Vegetables | See List II A and B. |
| 3. Fruit | See List III |
| 4. Bread exchanges (cereal products, vegetables high in carbohydrate: potatoes, corn, dried peas and beans, etc.) | See List IV |
| 5. Meat exchanges | See List V |
| 6. Fat exchanges (butter, margarine, cream, oil, etc.) | See List VI |

Within each group are listed the kinds and amounts of foods having approximately the same nutritional value of carbohydrate, protein and fat. Thus, any item in a given group or list may be *exchanged*, in the amount indicated, with any other item in that list, but not with items in other lists. Each item, in its appropriate quantity, is known as a *food exchange*. Thus, the bread exchange list includes such roughly equivalent items as two graham crackers, $\frac{1}{2}$ cup of cooked cereal, $\frac{1}{2}$ cup of baked beans, one small white potato, or $\frac{1}{2}$ cup of ice cream (omitting two fat exchanges elsewhere). The items of the fruit exchanges contain 10 grams of carbohydrate. The privilege may be given of substituting $1\frac{1}{2}$ fruit exchanges for one bread exchange.

The food exchange system of calculating diets is the simplest yet devised for the patient, dietitian and physician. The portions of food in each list

TABLE 2.—Sample Meal Plan (1800 Calories). Reprinted with permission of authors, J. W. Runyan, Jr., and D. Hurwitz and the New England Medical Journal (Joseph Garland, M. D.) from article entitled: "Management of the Ambulatory Diabetic Patient," New Eng. Med. Jour., 250:361-365 (March 4) 1954.

MEAL	EXCHANGES AND AMOUNT	EXAMPLE AND MEASURE	COMPOSITION			
			CARBO-HYDRATE	PROTEIN	FAT	CALORIES
Breakfast	1 fruit	Prunes — 2 (medium size)	10	—	—	40
	1 meat	Egg — 1	—	7	5	73
	2 bread	Toast — 2	30	4	—	136
	2 fat	Butter — 2 teaspoonfuls	—	—	10	90
	Coffee or tea (any amount)		—	—	—	—
	Totals	40	11	15	339	
Lunch	2 meat	Ham & cheese sandwich (cheese, 1 oz.; ham, 1 oz.)	—	14	10	146
	2 bread	2 slices	30	4	—	136
	Vegetable (List 2A)	Lettuce & tomato salad (any amount)	—	—	—	—
	1 fruit	Apple, 1 small	10	—	—	40
	1 milk	Whole milk — 1 cupful	12	8	10	170
	1 fat	Butter — 1 teaspoonful	—	—	5	45
	Coffee or tea (any amount)	—	—	—	—	—
	Totals	52	26	25	537	
Dinner	3 meat	Hamburg patties — 3 oz.	—	21	15	219
	2 bread	Mashed potato — $\frac{1}{2}$ cupful	30	4	—	136
		Bread — 1 slice	—	—	—	—
	Vegetable (List 2A)	Spinach (any amount)	—	—	—	—
	1 vegetable (List 2B)	Carrots — $\frac{1}{2}$ cupful	7	2	—	36
	1 fruit	Banana — $\frac{1}{2}$ (small)	10	—	—	40
	2 fat	Butter — 2 teaspoonfuls	—	—	10	90
	Coffee or tea (any amount)	—	—	—	—	—
	Totals	47	27	25	521	
Bedtime	1 milk	Whole milk — 1 cupful	12	8	10	170
	2 bread	Soda crackers — 6	30	4	—	136
	1 meat	Peanut butter — 2 tablespoonfuls	—	7	5	73
		Totals	42	19	15	379
		Grand totals	181	83	80	1776

are based on common household measurements which have been found to be satisfactory for clinical use. Weighing of foods is eliminated entirely. These diets allow for adequate food variations and substitutions so that most patients need not make radical changes in their customary eating habits. The carbohydrate, protein and fat composition of the sample meals plan is based on common eating practices (see table 2). They eliminate the monotony of rigid dietary schemes. Thus, when a bread or fruit exchange is prescribed there is a wide choice of items from the bread and fruit lists. Regarding "sweets," the families are told "There is nothing this patient cannot eat." Thus one-half ounce of candy, six ounces of soft drink or any other high carbohydrate item in suitable quantity, occasionally can be fitted into the diet in place of a bread exchange.

Beverages, Condiments, and Foods Allowed as Desired

The following foods have no appreciable carbohydrate, protein or fat if used in ordinary amounts and may be taken as desired, unless the physician finds a special reason to restrict them: Coffee, tea, clear broth; bouillon (fat free); gelatin, unsweetened; rennet tablets; cranberries, unsweetened;

lemon; mustard, dry; pickle, unsweetened; saccharine; pepper and other spices; vinegar.

"Specialty" foods for diabetics are not recommended. They are expensive. The information may be misleading. They are not needed, for the diabetic can usually eat all the natural foods (bread, cereal, unsweetened fruits, vegetables, etc.) in the proper amounts.

Division of Food Into Meals

The values for carbohydrate, protein and fat ultimately agreed upon, and their distribution between the various meals, must be regarded by the patient as unalterable except on order of the physician. Of the various factors which must be considered in the division of food, the most important is the type of insulin—regular, globin, NPH, etc. Feedings should be timed to coincide with the maximum action of the insulin being used. In the case of regular insulin this effect occurs two to four hours, intermediate insulins (globin, NPH and lente) six to eight hours and protamine zinc 12 to 16 hours, after administration. The failure to provide food at these crucial hours is the principal cause of insulin reactions in diabetics. The author subtracts from the daily caloric intake a substantial amount of protein, fat or both to be

eaten just preceding the maximal time of the action of the insulin.

Fat and protein containing foods are emptied from the stomach at a slow rate and produce a prolonged antihypoglycemic effect. Milk is an excellent product for this purpose. Fruits and other carbohydrates are emptied rapidly and are not useful as preventive foods. The physician knows that the between-meal hypoglycemia danger is minimized because the food availability then coincides more closely with the insulin availability. Moreover, when the food intake is spread out over longer periods of time, up to at least 14 hours of the day, and distributed more uniformly, much better control of glycosuria is possible.

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1. John, H. J.: Rational Treatment of Diabetes. Ohio State M. J., 52:1173-1180, November, 1956.
2. Wolf, H. J., and Priess, H.: Experiences with Fat-Free Diet in Diabetes Mellitus, Deutsche med. Wchnschr., 81:514-515, April 6, 1956.

Hazard of Large Doses of Vitamin K In Liver Disease

In patients with liver disease, the hypoprothrombinemia does not improve significantly following the administration of even large doses of either Vitamin K(Hykinone®) or Vitamin K₁ (Mephyton®). Indeed, in some of them, a further decrease in the prothrombin activity may occur.

It is therefore advisable to determine the results of Vitamin K administration within 24 and 48 hours. If no improvement in the hypoprothrombinemia has occurred, then no further Vitamin K should be given, but the patient should receive whole, fresh blood, as a therapeutic measure against the hemorrhagic tendency.—F. Steigmann, M. D., et al., Chicago: *Am. J. Gastroenterology*, 31:369, April, 1959.

Renal Cortex Cancer

A review of the pathology of 47 cases of carcinoma of the renal cortex indicates that this is one of the most treacherous neoplasms encountered in human pathology. Surgical specimens and/or autopsy studies were reviewed in 39 cases in which material was available.

The most common histological type of carcinoma observed was the clear cell type. Hemorrhage, necrosis, size of the mass, or position of the tumor within the kidney could not be correlated with survival. The grade of the tumor could not be used as an indication of biological course of the neoplasm. Factors demonstrated to indicate a more favorable prognosis were absence of vein invasion and a histological type composed entirely or predominantly of clear cells.—John H. Childers, M.D., Galveston, Texas: *Texas State J. Med.*, 55:96, February, 1959.

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEFFEL, M. D.
Columbus, Ohio, Chairman

Following is the summary of a case which was discussed before the Franklin County Pelvic Cancer Delay Committee on April 15, 1959, at its regular monthly meeting held at the University Health Center.

Case No. 69. The patient, a 53 year old colored woman, entered the hospital because of one month of vaginal bleeding. She was confused, and history was difficult to elicit. Pelvic examination revealed a deep necrotic ulcer had replaced cervix. The upper one-half of the vagina was involved by hard tumor tissue, and the pelvis was frozen. Tumor can be palpated in both lower abdominal quadrants.

Blood urea nitrogen on admission was 92 mg./100 ml., hemoglobin 4.8 grams. Clinical impression: Stage IV cervical carcinoma. Biopsy reported "Invasive squamous cell carcinoma of the cervix."

Comments

DR. WILLIAMS: A history of one month of bleeding is incompatible with these pelvic findings. Either intentionally or consciously to protect her family, this patient undoubtedly has been masking the signs of her pelvic malignancy.

DR. EZELL: The tragedy here lies in the fact that cervical carcinoma of this extent under our present day means of diagnosis is a preventable disease. We know from retrograde studies that this disease process has been present in this patient about 8 to 13 years.

DR. HOLZAEFFEL: The given length of delay of one month is erroneous. This patient must have had some type of bleeding or increased vaginal discharge for a period of many months rather than the single month she claims. *Patient delay*, at least six months. *Physician delay*, none. Patient entered hospital as terminal carcinoma with uremia. No therapy recommended. Treating or not treating a terminal patient is determined by patient's comfort.

Development of Duodenal And Gastric Ulcers

Duodenal ulcers usually are caused by hypertonus of the vagus nerves, producing excessive gastric secretion in the empty stomach and rapid passing of this juice into the less resistant duodenum.

Eighty per cent of *gastric* ulcers are caused by hypotonus of the vagus nerves, evidenced by decreased secretion in the empty stomach and gastric stasis. Prolonged contact of food with the antrum mucosa causes hypersecretion of gastric juice of humoral or hormonal origin, and prolonged contact with the hyperacid gastric content produces ulcer in the stomach.—Lester R. Dragstedt, M. D., Chicago: *Illinois M. J.*, 115:68, February, 1959.

Therapeutic Effectiveness of Tar-Allantoin Lotion (Alphosyl®) in Selected Dermatoses

Preliminary Report

ASHTON L. WELSH, M.D., and MITCHELL EDE, M.D.

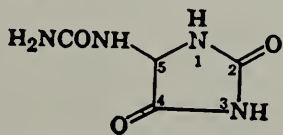
IN PATIENTS with certain chronic dermatoses, we and others have observed favorable response to therapy with tar cream, Tarbonis®* (5 per cent refined alcoholic extract of crude coal tar, lanolin and menthol, incorporated in a non-greasy, vanishing cream base). Response to the same cream was unfavorable in patients with certain acute inflammatory dermatoses, but when that cream was combined with 0.5 per cent hydrocortisone, free alcohol, Tarcortin®, prompt remissions of acute episodes of various dermatoses could be effected.¹

We make preliminary report, now, of results of our study of tar-allantoin lotion, Alphosyl®* (the same refined alcoholic extract of crude coal tar 5 per cent, plus 2 per cent allantoin, in lotion base), in patients with selected dermatoses.

Rationale for substitution of allantoin for steroid, and of lotion-form for cream-form is as follows. Coal tar is known to exert antipruritic, keratolytic and keratoplastic action. Consequently, during coal tar therapy of chronic, eczematous, scaling dermatoses, excoriation can be minimized, and the removal of scales and crusts can be facilitated (by spontaneous shedding). Lotions are less messy to apply, less heating, less occlusive; they are more readily absorbed; they are better suited (than creams) for application to hairy areas.

Allantoin is 5-Ureidohydantoin, also called glyoxyldiureide.² It is a bland, white, crystalline powder, which is stable in air. Strength of solutions can be decimated by excessive sunlight, hence any allantoin-containing liquid preparation should be dispensed in a dark bottle (just as Alphosyl is dispensed). Allantoin is slightly soluble in cold water, and readily soluble in hot water. Allantoin has no odor; it is nonstaining. It is represented by the following structural formula:

Allantoin. 5-Ureidohydantoin, glyoxyldiureide.



Allantoin presents an interesting history with regard to its action as a stimulator of tissue growth. Macalister³ found that extracts of comfrey root

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contained relatively high percentages of allantoin. He used both the crude extracts of comfrey root, and solutions of pure allantoin for topical therapy of chronic ulcers, intractable to other forms of therapy. He became convinced of the efficacy of allantoin as a nontoxic healing agent, when used topically, as well as internally (for the treatment of gastric and duodenal ulcers).

Robinson^{4,5} showed that allantoin, present in the excretion of maggots, was responsible for the healing of nonhealing wounds. Kaplan⁶ pointed out that allantoin induced healing by stimulating formation of healthy granulations, and by removing necrotic material. In his experience, allantoin appeared to act locally, just so long as it was in contact with wound-surfaces. Therefore, overgrowth of granulation tissue might be readily checked.

The therapeutic application of maggot therapy, as suggested by Baer and as reported by a number of other investigators,^{7,8} revealed exceptional results produced by allantoin in the treatment of osteomyelitis. Not only was there rapidity of healing, there was also rapid formation of healthy vascular granulations.

It has been pointed out that allantoin is the principal terminal product of purine metabolism in animals below man, and in man-like apes, resulting from the oxidation of uric acid through the action of uricase. While allantoin is regarded as an excretory material resulting from the metabolism of the cell nucleus, there is a possibility of the re-utilization of the purines liberated in catabolism.⁵ In its role as a stimulator of tissue growth (where development is inactive), the indications are that allantoin, and possibly some of its related substances, are more than waste products: they may be normally used in the nuclear structure of the cell itself. In short, allantoin stimulates granula-

*®Tarbonis, Tarcortin and Alphosyl are trademarks of Reed & Carnrick, Jersey City, New Jersey. Alphosyl was generously provided by Reed & Carnrick for this study.

tion and epithelization, and through a process of cell proliferation, there is acceleration of regeneration of normal epithelium.

A phenomenon of allantoin activity, recently reported by Flesch,⁹ appears to be its keratin-dissolving action, whereby a certain protein fraction of keratinized epithelium is dissolved. According to this investigator, it was found possible, *in vitro*, to reduce the cohesiveness of psoriatic scales by treatment with allantoin.

Experience of Others

Bleiberg and Saltzman¹⁰ reported study of response to tar-allantoin lotion (during an interval of seven months) by 50 psoriatic patients, when no other drug was used locally, or internally. Eleven patients cleared completely; 16 patients were greatly improved (all areas cleared except for a few resistant areas, usually on elbows or knees); 17 patients were moderately improved (at least 50 per cent cleared); and six patients were slightly improved (at least 25 per cent cleared). A number of these patients had scalp-to-feet involvement of many years' duration. There was no evidence of sensitization or irritation, even when tar-allantoin lotion was used on tender areas such as the anogenital and submammary regions. Half of the patients received ultraviolet light at intervals ranging from one week to three weeks, and while these patients seemed to improve a little more rapidly, it was felt that use of ultraviolet light was unnecessary. Response of a small series of patients with eczema was observed, but, in this group, according to Bleiberg and Saltzman, tar-allantoin lotion appeared to have no value.

There have been other favorable reports^{11,12,13} regarding response by psoriatic patients, wherein it has been pointed out that therapy with tar-

allantoin lotion permits complete avoidance of the potential hazards of certain other methods of treatment, such as superficial x-ray, heavy metals and corticosteroids, for the control of what may be a lifelong dermatological problem.

It seemed to us that combination of coal tar and allantoin, in lotion form, might possess certain advantages, particularly for the treatment of those persistently scaling, chronic dermatoses, when a protracted dermatological problem exists; and when there is involvement of large body areas, including scalp and mucous membranes.

Method of Study

For our study, we selected patients (drawn from private practice), who had been under our care for at least two years—some of them for as long as 12 years. All were known to have chronic, scaling dermatological problems, resistant to usual therapeutic regimens. Patients were provided with tar-allantoin lotion (the only topical medication used), in plain, unmarked bottles. Patients were instructed to apply the medicament, first, to a small area, and to watch for and report any untoward reaction, such as increased irritation, erythema, and the like, before application was made to large areas.

Application of tar-allantoin lotion was prescribed from one to four times daily (usually twice daily), depending upon the condition, and the response. Internal medications were administered as indicated. (Inasmuch as all patients had chronic, rather than acute inflammatory disease processes, therapy with steroid hormones was not indicated, or required). Actinic therapy was administered, where, and as indicated. All patients were observed at weekly intervals.

This report is based on a study period of six months. The accompanying table 1 indicates dis-

TABLE 1.—Response to Therapy with Tar-Allantoin Lotion

Disease Entities	Number of Patients	DURATION OF THERAPY IN MONTHS				RESPONSE			
		Less than 2	2 - 4	4 - 6		100% Cleared	75 - 99% Improved	50 - 74% Improved	No Improvement
Atopic dermatitis (with lichenification)	18 (15)	7 (1)	11 (11)	— (3)		5 (2)	11 (2)	2 (9)	— (2)
Chronic infectious eczematoid dermatitis	68 (41)	26 (15)	27 (22)	15 (4)		42 (13)	13 (13)	11 (13)	2 (2)
Contact dermatitis (with eczematization and lichenification)	18 (13)	9 (11)	6 (1)	3 (1)		4 (2)	5 (4)	9 (6)	— (1)
Lichen planus (hypertrophic)	20 (18)	2 (12)	16 (5)	2 (1)		7 (5)	10 (6)	3 (5)	— (2)
Neurodermatitis (localized)	24 (19)	8 (3)	7 (14)	9 (2)		4 (2)	16 (7)	4 (10)	— —
Psoriasis	62 (54)	12 (9)	10 (11)	40 (34)		29 (23)	26 (15)	7 (16)	— —
TOTALS	210	64	77	69		91	81	36	2
CONTROL SERIES	(160)	(51)	(64)	(45)		(47)	(47)	(59)	(7)

ease entities, number of patients, duration of therapy, and response thereto. Figures enclosed in parentheses indicate the number of patients who had received, under our observation, previous therapy with tar cream (5 per cent refined alcoholic extract of crude coal tar, lanolin and menthol, incorporated in a nongreasy, vanishing cream base). Responses of these patients were known, and we have considered such group as constituting our "control series," for purposes of this evaluation.

Comment

We observed no reactions following use of tar-allantoin lotion by any of the patients in our series. A number of those patients have been under observation for years, and were known to have multiple, proven sensitivities. Individuals with atopic dermatitis, who had been known to react to sun, when using other tar-containing topical agents, did not react in the same fashion during therapy with tar-allantoin lotion.

For patients with anogenital and intertriginous involvement, where creams and ointments are too occlusive, tar-allantoin lotion is most beneficial. For patients with scalp involvement, tar-allantoin lotion may be applied at night, well rubbed into scalp and hair and, when followed by a cleansing shampoo next morning, or as often as is indicated, crusts, scales and debris are effectively removed.

Tar-allantoin lotion disappears into the skin (or scalp) without leaving a film of excess medication, thus permitting maximum therapeutic utilization of the active ingredients. (Excess lotion can be removed, by rinsing with water). Tar-allantoin lotion does not impede exudation, sweating, or evaporation; it is nonstaining; it does not have enough odor to make daytime use objectionable.

When many patients whose conditions were static or whose improvement was slow, were switched from therapy with tar in cream form to tar-allantoin lotion, there was increase in both degree and rate of improvement, according to our own observations, and comments volunteered by patients themselves.

Results of our preliminary study indicate that whenever, and wherever coal tar therapy is indicated (for persistent, scaling, eczematous dermatoses), tar-allantoin lotion exerts greater healing activity than does the same coal tar formulation in cream form without allantoin. We base this conclusion on our observation of response by the same patients, during various episodes of recurrent dermatoses, when coal tar therapy was previously administered in cream form, and later, in combination tar-allantoin lotion form. The reason why the combination of coal tar and allantoin exerts this increased healing power is obscure, at this writing.

We postulate, however, that the addition of allantoin facilitates removal of scales and crusts, stimulates epithelization, increases the process of cell proliferation, and so promotes regeneration of normal epithelium, while the coal tar exerts its well-known antipruritic and anti-eczematic activity.

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Prevention and Treatment Of Simple Obesity

For the present, the practical considerations in the prevention and treatment of simple obesity are:

(1) Recognition and control of the social and emotional factors which make middle-aged obesity a chronic problem.

(2) Awareness of the individual's caloric requirements, as well as the approximate caloric content of foods, especially those concentrated sources of empty calories.

(3) Establishment of a program of regular physical activity that is compatible with ability and state of health; perhaps better stated as the avoidance of inactivity.

(4) Employment of long range reducing diets which meet basic nutritional requirements for protein, minerals, and vitamins, and which have the objective of long term revision of faulty food habits, rather than spectacular short term results (i. e. avoid fad diets and magic proprietaries).

(5) For obesity of childhood and adolescence, encouragement of increased energy output, with less emphasis upon decreased food intake.—G. H. Berryman, M. D., Evanston, Ill.: *Illinois M. J.*, 115:74, February, 1959.

Refractive Errors

A Case Report on Preventable Blindness

WILLIAM H. HAVENER, M. D.

A BLIND EYE is a serious loss to both patient and community. Awareness of the preventable nature of a significant portion of this blindness should help in reducing the incidence of such tragedies.

Case Report

This 37 year old man had always required very strong spectacle correction for hyperopia. His eyes were smaller than normal, the corneas measuring 9 mm. (normal size 12 mm.) in horizontal diameter. During routine eye examination, his intraocular pressure was found to be 39 (normal maximum 25). Miotic therapy now maintains his pressure within normal levels, and has prevented development of glaucomatous changes.

Discussion

Although there is a widespread lay impression that improper care of refractive errors may lead to blindness, this is an entirely false concept. Associated structural defects may, however, coexist with refractive errors. Knowledge of such associations may lead to earlier diagnosis of serious disease. The two commonest relationships are hyperopia-glaucoma and myopia-retinal detachment.

The hyperopic eye predisposed to development of glaucoma is ordinarily a small eye, either throughout or only in its anterior portion. This is recognized fairly readily because of reduced corneal diameter. The normal horizontal corneal diameter is 12 mm. Eyes with a corneal diameter as small as 10 mm. or less are very likely to develop chronic simple glaucoma. Apparently the decreased size of the outflow mechanisms in the anterior chamber angle, or some such structural change, permits aqueous outflow to be impeded earlier by the degenerative changes of age. It should be emphasized that this type of glaucoma is quite distinct from congenital glaucoma. The soft structures of the infant eye are readily stretched by increased intraocular pressure, resulting in the LARGE cornea so characteristic of infantile glaucoma.

Medical management of the patient with 10 mm. or smaller corneas should include tonometry at least every two years after the age of 30. Inasmuch as sight lost through glaucoma cannot be restored, its diagnosis is ideally made by early suspicion, rather than by the finding of optic atrophy with uncorrectibly reduced vision.

Myopia is infrequently associated with serious degenerative changes of the retina and choroid. Only about one in a hundred myopes are so affected. Diagnosis of this condition of "degenerative myopia" cannot be made by observing the dioptric strength of the patient's glasses, but requires ophthalmoscopic examination.

The characteristic features of degenerative my-

The Author

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opia include rather marked chorioretinal atrophy in a well defined crescent shape temporal or inferior to the optic disc; irregularity and yellowish-orange or dirty-grey discoloration of the chorioretinal pigmentation; abnormally increased visibility of the choroidal vessels; degeneration of the macula; exaggerated peripheral cystic retinal degeneration; and egg-shaped elongation of the eye which requires considerably more minus lens power to observe the posterior pole than the periphery. Such eyes are so markedly predisposed to retinal detachment that about a half of all detachments in patients younger than 40 years occur in degenerative myopes (who comprise about 0.05 per cent of the population). Knowledge of this predisposition will cause justifiable alarm when a young degenerative myope complains of a sudden onset of "floaters" in his vision. This symptom often gives the first warning of a retinal tear.

Many stories are heard of patients who have gone blind because of improperly prescribed glasses. This is only a half-truth. The most erroneously fitted glasses cannot damage an eye—though there is no doubt they may result in discomfort, fatigue, headache, and great annoyance. The element of truth in such stories is related to the high incidence of serious eye disease and the fact that early symptoms of many serious diseases are indistinguishable from those of refractive error.

Military statistics indicate that 5 of 100 Americans of draft age have uncorrectibly reduced vision of 20/200 or less in one eye. No statistics are available for monocular visual loss in older age groups, but it is clinically evident that the degenerative diseases and the additional years of exposure to trauma cause a progressively higher incidence of serious visual loss. Because of the great frequency of eye disease, it is in order to conclude that **all persistent eye complaints deserve medical evaluation**, and not simply a refraction.

Maternal Mortality Studies in Ohio: Progress and Results*

ANTHONY RUPPERSBERG, JR., M. D.

DURING the past 40 years in the United States, Obstetrics has achieved progress and created a record which is almost unbelievable. Perhaps the keenest barometer indicating this progress is the maternal death rate. Its dramatic change reflects graphically a gradual but sure decline which covers the medical profession with a well-earned coat of glory. Yet we must not cease the vigil or diminish the toil and effort which produced this improvement lest we give rise to insidious practices that may cause this pendulum to swing back to the hazardous rates of yesterday.

One of the most potent factors in reducing the maternal mortality rate is a systematic study of maternal deaths. In Ohio, a number of studies¹ have been started in the past 25 years, and indeed it would be remiss to omit a smart salute to those who acted as pioneers in this work two decades ago.

Following are some brief facts concerning two of the most recent, most extensive studies now operating in Ohio—the Franklin County Maternal Mortality Study, and the Ohio State Maternal Mortality Study. The Franklin County Study has operated for 10 consecutive years. Later we shall describe how the pattern of organization and operation of this study was utilized to plan and develop the Ohio State Study.

We feel that the Ohio study differs from those which our friends have established so effectively in other states, in several ways: It is a voluntary study in which coercion is not employed; it is free from disciplinary action or criticism from any member of the Committee, and it employs an educational program to improve maternal health.

Franklin County Study

In 1947, Drs. Richard L. Meiling and Anthony Ruppertsberg, Jr., began a careful preliminary study of "puerperal deaths" which occurred in Columbus, Ohio. Figures available in the local bureau of vital statistics were compared with those of other communities of similar size. Especially for 1935 (fig. 1), the "puerperal death rate" of 9.1 per 1,000 live births was found to be extremely high in comparison to other areas. The figure was even more impressive when we discovered abortions and ectopic pregnancy deaths were not included in this formidable rate.

Realizing that an abundance of educational material could be gleaned from details surrounding each maternal death, the two physicians planned and instituted a systematic study of maternal deaths occurring in Franklin County, including Columbus.

The study officially commenced on January 1, 1948. At first, each case was investigated with great difficulty. Data were recorded on a questionnaire modified from the form used by the Children's Bureau, Department of Labor, Washington, D. C., for the "15 States Study." Since the form was used in New York City and Philadelphia, it was felt this would enable the Committee to use material collected in *this* community, for a comparative study with *other* communities in the

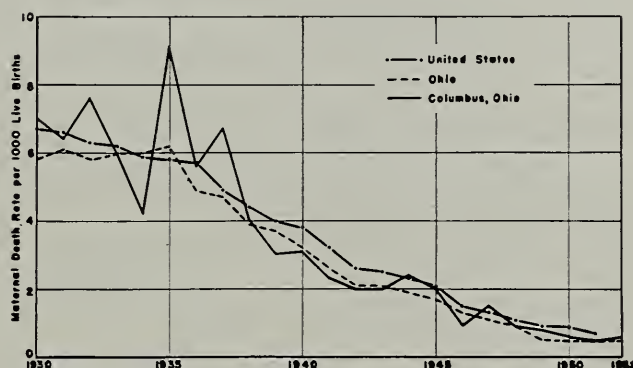


FIG. 1. Maternal Death Rate per 1000 Live Births, United States, Ohio, and Columbus, Ohio, 1930-1952.

future. Every source of information was explored from health department to hospital.

In the early days the co-founders were received with suspicion and contempt by the medical public, which was reluctant to accept the policies of anonymity and education purported by the study. Gradually the sincerity of the two-man Committee filtered through resistant minds; opposition gave way to acceptance.

As progress was made, the founders formally presented the project to fellow members of the Columbus Obstetric-Gynecologic Society, October 27, 1949. By unanimous vote the Society accepted support of the study and appointed a Committee, including the founders, to perpetuate the project. The study became an educational medium for Franklin County physicians; each year the Committee published a full report of findings in the *Bulletin of The Columbus Academy of Medicine*. After five years a voluminous report

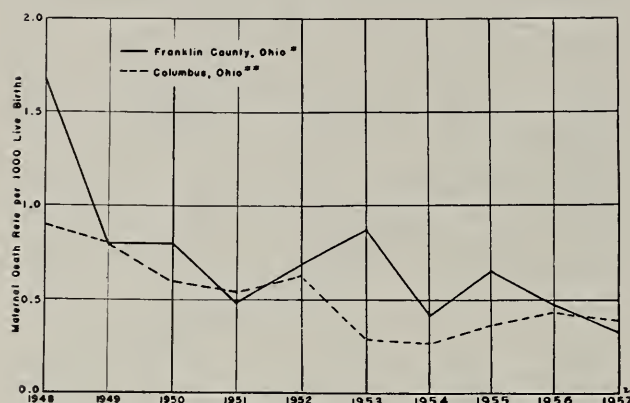
*Presented on a Panel, "Obstetric Mortality; Current Findings of State Maternal Mortality Committees," A. C. O. G. Meeting of Distr. V, French Lick, Indiana, September 27, 1958.

carrying all details and findings of the Committee was published in *The Ohio State Medical Journal*.²

From observations of the Committee, the study demonstrated:

1. Need for better education in obstetrical problems.
2. Need for early diagnosis of complications.
3. Need for adequate consultation.
4. Need for proper facilities for appropriate treatment.
5. Hazards of unwarranted obstetrical and surgical intervention.
6. Need for better records.

The Franklin County Maternal Mortality Study just completed a decade of operation and continues in its eleventh year as an accepted project in the community. A gradual decline in the 10-year county maternal mortality rate is shown in figure 2; whereas the rate was 1.6 per 1,000 live



*Based on maternal deaths, included in Franklin County Maternal Mortality Study of deaths which occurred in Franklin County.
 **Based on maternal deaths, resident of Columbus, and recorded by the Columbus (Ohio) Health Department.

FIG. 2. Maternal Death Rate per 1000 live births, Franklin County (from the Maternal Mortality Study) and Columbus, Ohio (from Health Department records).

births in 1948, it was 0.35 per 1,000 in 1957! A complete report to the medical public was published in the Columbus Academy *Bulletin*.³

A shift in the distribution of principal causes

of deaths from (1) hemorrhage, infection and toxemia, in 1948, 59.1 per cent of the total, to (2) "Other causes" in 1957, 57.1 per cent of the total shows an interesting prevalence of bizarre causes of maternal deaths, in the later days of the study, (Table 1).

Ohio State Study

Using plans of the Franklin County Maternal Mortality Study as a pattern three other important studies have been organized successfully: (1) The Ohio State Maternal Mortality Study (1953); (2) The Franklin County Pelvic Cancer Delay Study (1954); and the Franklin County Perinatal Mortality Study (1956).

Following numerous conferences with officials of the Ohio State Medical Association and the Ohio Department of Health, founders of the Franklin County Study felt that a study of maternal deaths for the 88 counties of Ohio would be a worthwhile project. As a sponsor for the vast project, the Ohio State Medical Association representing 9,000 Ohio physicians was selected. The project was presented on the floor of its House of Delegates April 23, 1953. The initial resolution was adopted, the project was explored further, approved by The Council, and the Committee on Maternal Health was confirmed on April 15, 1954.

Weeks and months of meticulous planning followed. Every County Medical Society, after appointing a Committee on Maternal Health, would have benefit of a local Maternal Mortality Study, yet forward duplicates of the material to the State Committee for compilation of a State Study after a final review.⁴

Policies and terminology employed in the Franklin County Study were examined, evaluated and finally were selected by the Committee for use in the Ohio Study.⁴ A few are listed herewith:

1. **Maternal Case:** If death occurs in a woman in the State of Ohio, who is in a state of pregnancy or within 12 months (one year) following the date of termination of her pregnancy, regardless of the length of her gestation, her case is

TABLE 1.—Maternal Deaths Due To Hemorrhage, Infection, Toxemia, and Other Causes, Franklin County, Ohio, 1948 and 1957

1948		No.	1957		No.
Hemorrhage	}	4	Hemorrhage	}	1
Infection		6	Infection		2
Toxemia		3	Toxemia		0
Other causes		9	Other causes		4
Cardiac		4	Postabortal mole		1
Embolism		1	Pulmonary Emboli		1
Anesthesia		1	Cardiac arrest		1
Hyperemesis		1	Suicide		1
Pneumonia		1			
Pheochromocytoma		1			
Total		22	Total		7

included in this maternal mortality study as a "maternal case."

2. **Maternal Death:** Data on maternal cases will be compiled, and after final study and appraisal, each case will be classified by the Committee on Maternal Health as a *maternal death* or a *nonmaternal* (nonobstetric) *death*. The term "maternal death" is applied to include all deaths in women, with either a nonviable or viable fetus, during pregnancy, labor or the puerperium from causes directly due to the pregnant state, such as abortion, ectopic pregnancy, placenta previa, etc., as well as associated causes such as heart disease, embolism, tuberculosis and other accidental complications of pregnancy, but not necessarily limited to these alone.

3. **Nonmaternal Death:** Death not connected directly or indirectly with the pregnant state (non-obstetric death).

4. **Puerperium:** In this study the *puerperium* is considered to last 365 days (one year) for the purpose of collecting "maternal cases." Although the ultimate appraisal of data available in a given case may reveal no connection (either directly or indirectly) between the cause of death (as certified) and the pregnancy, all patients who die in this (12 month) puerperium should be included for study, lest a real "maternal death" be erroneously omitted. This is of especial importance in the case of chorioepithelioma and cervical cancer.

5. **Not Delivered:** For the purposes of this study, the term "not delivered" is employed to describe the pregnant state of a woman who dies before the expulsion or extraction of the products of conception. It applies to the case of ruptured ectopic pregnancy when the patient dies without operation as well as to the full term (uterine) pregnancy.

These definitions in our studies conform to terminology used in the International Code of Vital Statistics for the purpose of uniformity.

Subsequent steps in planning included orientation of Committee members and the establishment of an operating liaison with Ohio Department of Health, Ohio Coroners' Association, Ohio Hospital Association and the Ohio Osteopathic Association. Physicians throughout Ohio were apprized of the project through articles in *The Ohio State Medical Journal*.⁴ County Medical Societies received additional information by correspondence from the President of the Ohio State Medical Association.

Information for maternal cases was obtained from death certificates on file in the Division of Vital Statistics, Ohio Department of Health. This was transcribed onto standard questionnaire forms,

which were then forwarded to the County Maternal Health Committees through committee members representing Councilor Districts. Upon completion of each form, data would be transcribed for local use by the Committee, after which the form would be returned through channels to the State Committee on Maternal Health, for study, classification and additional statistical use, on an anonymous basis.

Functions of State Committee

The Committee on Maternal Health of the Ohio State Medical Association has the following functions:

1. To operate a study of all maternal deaths occurring in Ohio.

2. Education and training:

- a. Publish case reports and educational "comments" as well as statistical analyses, monthly in *The Ohio State Medical Journal* under the heading "Maternal Health in Ohio."

- b. Support an education and training program in obstetrical anesthesia, operated for Ohio physicians by the Ohio Society of Anesthesiologists.

- c. Prepare and publish "Guiding Principles for Obstetric Care"⁵ (minimum standards).

- d. Prepare educational data on maternal mortality in the form of "packets" for use in county meetings; visual aids (slides and films) are included.

- e. To assist local societies in preparing mortality and maternal health exhibits, for use in meetings.

3. To advise The Council of the Ohio State Medical Association on matters pertaining to maternal health in Ohio.

The Ohio State Medical Association Council is especially proud of the "Guiding Principles for Obstetric Care." This difficult project required three years of work and deliberation by the Committee on Maternal Health. As a document, it has demonstrated its value many times. The purpose of the "Principles" is threefold:

1. No patient to die a preventable death if the standards are met.

2. The "Principles" are employed in the education and training program for Ohio physicians.

3. The Committee uses the standards as a uniform guide in the maternal mortality study (assessing responsibility, etc.).

Statistics

Although we are young in this maternal mortality study project compared to other states, we have some interesting figures to present. Case col-

lection began January 1, 1955; statistics completed to date include only that year.

From the Ohio Study during 1955, there were 96 maternal deaths among the 119 cases studied.⁶ Of the 96 cases, 52 per cent were voted preventable deaths. Of the 50 preventable deaths, the Committee voted 11 as patient responsibility (P_1), 33 personnel responsibility (P_2), and six the responsibility of both (P_1 and P_2).

Briefly listing the four principal causes of 96 maternal deaths, *hemorrhage* led with 15 cases (fig. 3). Next in major causes was *anesthesia* in

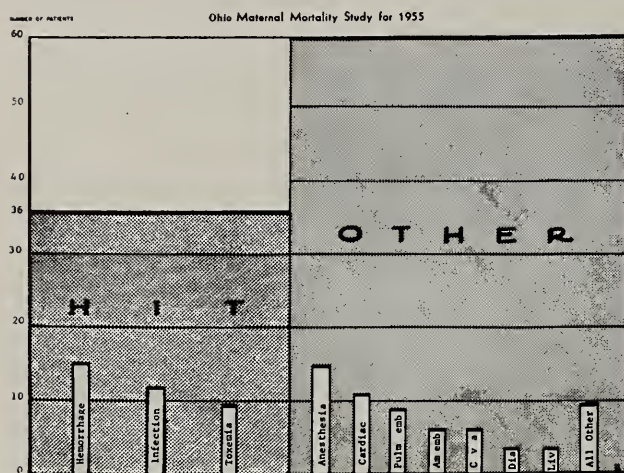


FIG. 3. Classification of primary causes of death; 96 maternal deaths, 1955.

14 cases! In order, there followed *infection* (12 cases), *cardiac disease* (11 cases), and *toxemia* (9 cases). This figure reveals also that hemorrhage, infection and toxemia (36 cases) as the prevailing triad of former years, was replaced by "other causes" (60 cases), including anesthesia, cardiac, pulmonary emboli, amniotic fluid emboli, etc.

In Ohio, there were 222,689 live births reported during 1955. From this maternal mortality study there were 96 maternal deaths, with a maternal mortality rate of 4.31 per 10,000 live births. Currently cases are being compiled for 1956, 1957, and 1958; when the data for each year are completed, subsequent annual reports will be forthcoming.

Use of Material

Realizing that the wealth of data was obtained for the study through the cooperation and labor of many individuals throughout Ohio, the Committee desires to take full advantage of the material by employing it in an educational program:

1. From the material, anonymous case reports are published monthly in *The Ohio State Medical Journal* (Maternal Health in Ohio column).
2. Material is used to augment the obstetric anesthesia training program in Ohio.

3. From the study of maternal deaths, the Committee developed "Guiding Principles for Obstetric Care" as a guide for physicians in Ohio.

4. Packets containing lecture outlines and visual aids are prepared and distributed on request, to local societies for use in presenting maternal mortality programs, on a loan basis without charge.

5. Material from the study is furnished to construct exhibits for display at local lay and medical meetings, to improve maternal health in Ohio.

This total program is designed not only to prevent mothers from dying, but also to improve maternal health, through better obstetrical care; thus mothers may live longer, healthier lives and enjoy the privilege of raising their children. To effectively operate this vast program a well organized, *large* team is necessary. From the expectant mother, lay public, physicians, nurses, and many other members of the team, interest and cooperation must be obtained through education and a dissemination of pertinent information concerning maternal health.

Summary

1. The organization, structure and function of the Franklin County Maternal Mortality Study Committee, and the Committee on Maternal Health, Ohio State Medical Association are presented.

2. A brief summary of principal causes of maternal deaths in Franklin County, and the State of Ohio for *ten* years and for *one* year, respectively, are shown.

3. Current use of material obtained from these studies in local and statewide educational programs is demonstrated.

4. The pattern of planning for a well organized maternal mortality study (Franklin County) may be used to organize other similar studies (Ohio Study, Franklin County Pelvic Cancer Delay Study, and the Franklin County Perinatal Mortality Study).

5. Observations and experiences obtained from the maternal mortality study provide an excellent source of material for use in a program to reduce maternal mortality and improve maternal health.

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A Clinicopathological Conference

Edited Under the Auspices of the Ohio Society of Pathologists

CHARLES BLUMSTEIN, M. D., *President*

Presentation of Case

THIS 34 year old colored man was admitted to the University Hospital, Columbus, Ohio, with complaints of cough, chest pain and dyspnea. Six weeks prior to admission he noticed the onset of persistent productive cough which was progressive in severity and accompanied by fever, chills and recurrent epistaxis. One week later the patient had considerable congestion and obstruction of his upper respiratory tract and was given medication, which he disregarded after two days. On the following day the patient had several episodes of hemoptysis and shortness of breath and his local doctor again gave him some medication which relieved somewhat his shortness of breath.

During the three weeks prior to his admission the patient developed dyspnea on exertion, orthopnea, chest pain, pedal and facial edema and occasional episodes of nausea and vomiting. At that time he was told that he had high blood pressure and was then referred to University Hospital for further diagnosis and treatment. The patient had had most of the childhood diseases except for scarlet fever, and he also had had many sore throats. For the last five years he had enjoyed perfect health.

Physical Examination

The patient was a well-developed, well-nourished Negro man who appeared chronically ill and in moderate respiratory distress. His blood pressure was 180/100, pulse rate 100/minute, respiratory rate 24/minute, temperature 99.2° F.

He was somewhat lethargic and uncooperative. His skin was very dry and scaly. There was moderate periorbital edema. His fundi exhibited some variations in the caliber of the vessels and splinter and flame hemorrhages with soft and hard exudates but no papilledema. His nose was obstructed with blood-stained mucus and the nasal mucosa was inflamed. His tonsils were enlarged and inflamed. There were a few submaxillary nodes palpable bilaterally.

His lungs were clear to percussion and auscultation. His heart was moderately enlarged; its rhythm was regular with a grade 2 apical systolic murmur. His abdomen was not tender. The liver extended 4 fingerbreadths below the right costal margin but was firm and not tender. There was 2 plus pitting edema of legs and feet and slight

Presented by

- James F. Schieve, M. D., Columbus, and
 - J. M. B. Bloodworth, Jr., M. D., Columbus.
- Edited by Emmerich von Haam, M. D., Columbus.

edema of the hands. Neurologic examination was within normal limits.

Laboratory Data

On admission the urine specific gravity was 1.003, pH 5, protein 160 mg.; 10 to 15/cu.mm. white blood cells and occasional red blood cells per high power field, and a few uric acid crystals. The white blood count was 5,500/cu.mm. with a normal differential count; hemoglobin was 4.7 Gm.; hematocrit, 13 per cent; platelets numbered 192,000/cu.mm. Sick cell preparation was negative. Antistreptolysin titer was 12 units. C-reactive protein, negative. Latex fixation test and lupus erythematosus preparations were also negative. Serological tests for syphilis were nonreactive.

Blood urea nitrogen was 164 mg./100 cc.; creatinine 25 mg.; fasting blood sugar 124 mg.; 2-hour postprandial blood sugar 155 mg. The glucose tolerance test proved the patient was a mild diabetic. Inorganic phosphorus was 10.7 mg.; CO₂ combining power 30 vol. per cent. Sodium, potassium, chlorides, van den Bergh, thymol turbidity, total protein and albumin/globulin ratio, prothrombin time, cholesterol and cholesterol esters, bromsulphalein test, Sulkowitch test and calcium were within normal limits.

Routine cultures and cultures for acid-fast bacilli on urine and sputum were negative. Serial electrocardiograms showed T-wave and ST segment changes consistent with acute pericarditis. Chest x-rays were compatible with chronic congestive heart failure, with a slight increase of the transverse diameter of the heart and mild pulmonary vascular congestion. X-rays of the abdomen showed an enlarged liver, mild paralytic ileus and ascites. The kidneys were not excessively enlarged.

Hospital Course

The patient was given large doses of penicillin orally and repeated blood cultures were obtained. All cultures proved to be negative and penicillin was discontinued on his third hospital day. His

anemia was corrected and controlled by intermittent transfusions of packed red cells, but they seemed to contribute little to his progress. Subsequent urinalyses exhibited a fixed specific gravity of 1.009 and also continued to show pyuria and hematuria, but several urine cultures were negative. The patient was given larger doses of Kynex® and Chloromycetin,® but he showed little improvement.

On his eleventh hospital day a light to moderate growth of coagulase-positive *Staphylococcus aureus* was reported in his urine. On the sixteenth hospital day culture of his throat revealed predominance of coagulase-positive *S. aureus*. The administration of antibiotics was continued until his seventeenth hospital day. The patient continued to receive intravenous fluids, but he became a serious problem in fluid and electrolyte balance. Four days prior to his death his CO₂ combining power was corrected to 53 vol. per cent; however, his sodium was 124, chlorides 74 and potassium 8.2 mEq. Despite intensive therapy his uremia was progressive and on the day prior to his death the blood urea nitrogen was 256 mg./100 cc. The patient remained hypertensive and had a progressively downhill course. He died on his 23rd hospital day.

Clinical Discussion

DR. SCHIEVE: This patient was admitted with chief complaints of cough, chest pain and dyspnea of about six weeks' duration, which means that we have a relatively young person with either heart or lung disease, or both. After some weeks of persistent cough, fever, chills, recurrent epistaxis and hemoptysis he developed dyspnea on exertion and orthopnea, chest pain, edema of the face and feet, and episodes of nausea and vomiting. This time the patient found out about his high blood pressure and came to the hospital.

Such a history indicates that this patient is apparently having some elements of congestive heart failure, apparently on the basis of hypertension, but it also suggests that he had some type of pneumonia, possibly bronchopneumonia. From the hemoptysis one could guess that the patient had some pulmonary infarction, but we are not sure. We usually do not observe epistaxis in congestive heart failure, although we see it sometimes in patients with hypertension. The nausea and vomiting could be from medication, although he did not take too much. It also could come from a congested liver, or it could be related to the development of uremia.

Chronic Renal Disease

The past history is essentially not helpful but it does state that the patient had many bouts of

sore throat, which may be pertinent or not. We do know that he had been relatively healthy until the onset of this recent illness. We don't know how long he had hypertension. I would suspect from the course of the disease and the man's age that this hypertension is secondary to renal disease, and I would suspect that the renal disease had been present for a long time and was clinically relatively asymptomatic.

The physical examination revealed moderate elevation of the blood pressure, tachycardia, increased respirations and slight fever. He appeared chronically ill and was in moderate respiratory distress. He could be breathing with difficulty from his heart if he was in congestive failure, he could have Kussmaul type respirations, or he could have some difficulty in breathing from his anemia. Perhaps it was a combination of all of them. Examination of the fundi indicated that he had vascular disease with a severe hypertension or albuminuric retinopathy of long standing.

His enlarged lymph nodes in the submaxillary area could come from infection around his teeth and gums, or from his uremia. I am inclined to think that it is a local affair and that these nodes are not too important for the final analysis of his problem.

I am bothered by the fact that his lungs were clear to auscultation and percussion, but I guess that the patient had treatment for congestive failure before he came to the hospital. One can have pulmonary edema without rales in the chest, but it is difficult to make a diagnosis of bronchopneumonia without hearing some rales, although this could happen. From the history and the other part of the physical examination I am inclined to think the man did have some type of pulmonary disease, possibly of interstitial character which was missed with the stethoscope.

Not Polycystic Disease

Examination of the heart gave findings which I think would fit with a hypertensive heart. The patient had peripheral edema and a normal neurological examination. I assume that the kidneys were not palpable and I assume that the rectal examination was normal. This is important in the evaluation of any patient with chronic uremia. If the examination was done carefully and nothing missed, I would say that we have a 90 per cent chance of being right in saying that this patient did not have polycystic kidney disease.

His laboratory data tell us a great deal. First they tell us that the patient had essentially a fixed specific gravity of his urine, with proteinuria and consistent microscopic hematuria and pyuria. He had a marked anemia, an essentially normal differ-

ential blood count, and a negative sickle cell preparation. His blood urea nitrogen of 164 mg./100 cc. on admission with a very high creatinine and his anemia make me think that this man probably had been in uremia for a long time and that he did not suffer from an acute renal disorder of any type.

— or Diabetic Nephropathy

We are then faced with the problem of an elevated fasting blood sugar, a 2-hour postprandial blood sugar of 155 mg. per 100 ml. and a glucose tolerance test which suggests that the patient was a mild diabetic. We do know that many patients with long-standing diabetes often will develop a renal lesion and can have renal failure which is very difficult to manage. I don't believe, however, that I have ever seen a patient with diabetic kidney disease presenting this type of history. I am not as disturbed by the fact that the diagnosis of diabetes was never made before, as by the fact that the illness was so rapid and that he had no history of edema for weeks and months before he had the final difficulty with renal failure.

Furthermore, his total proteins, his albumin/globulin ratio and cholesterol do not suggest a nephrotic element in his renal disease, and this I would expect to see in most patients with diabetic renal failure. In regard to his fasting blood sugar, there are many things that could make it elevated, and his 2-hour postprandial sugar is not too abnormally high. The glucose tolerance curve might be mildly abnormal in a sick man who probably had not eaten well, and so I have decided to regard that information as not pertinent to his fatal illness.

— or Pyelonephritis

The serum and urinary calcium determinations were within normal limits, and in view of the fact that there are no other suggestive evidences of a disease of the calcium metabolism, I don't believe we can relate this patient's renal failure very well to any metabolic disorder of this type. We know that on admission at least his urine did not have acid-fast bacilli or any other organisms, which brings us to the question of whether this man had chronic pyelonephritis. I do not think that he did have chronic pyelonephritis as a primary main illness. First, he is a rather young man with normal prostate, and then his urine cultures were negative. Of course we can have negative cultures and still find pyelonephritis, which means that we probably really cannot rule out this diagnosis. The electrocardiograms suggest

that the man may have had pericarditis, and if he did, I would expect that it was on the basis of uremia.

— or Collagen Disease

There was no indication that the patient had a collagen disease. As you know, lupus erythematosus can produce chronic nephritis. Usually, however, this nephritis will be accompanied by nephrotic syndrome and I don't believe we have such a history here. When the patient came into the hospital it was thought that he might have subacute bacterial endocarditis. This apparently was partially ruled out on the basis of negative blood cultures and because of lack of symptoms suggesting such a disease.

Transfusions did not help him. The urinary concentration was fixed at 1.009. He continued to show pyuria and hematuria. Later on a positive urine culture was obtained and he was treated with sulfonamides and Chloromycetin, none of which helped. I think it is of importance for the diagnosis that he rapidly became worse and his renal failure progressed rapidly, although he had been quite well until six weeks before his admission to the hospital. We see this quite often in people who exist with a borderline renal function once they go into clinical uremia. He was difficult to treat in the hospital because every time they tried to hydrate him to bring his blood urea nitrogen down, he got into electrolyte imbalance and developed a dilution syndrome.

I think then that this is a case of chronic renal disease in a young man who did not have diabetes, polycystic kidney disease, subacute bacterial endocarditis, lupus, chronic pyelonephritis, malignant hypertension or obstructive uropathy. This leaves us with the diagnosis of chronic glomerulonephritis and in its most common clinical type—a patient with chronic renal failure who never had a history of acute nephritis. The age and sex fit the diagnosis, the rapid rise of blood urea nitrogen at the end of his illness, the anemia, the heart size, blood pressure, epistaxis, and all other clinical symptoms suggest such a diagnosis. I believe that he also had cerebral edema, pericarditis, pneumonitis perhaps of the uremic type, and that the autopsy will show small scarred kidneys and an enlarged heart.

General Clinical Discussion

DR. BLOODWORTH: I wonder if Dr. Hamwi would say a few words as to whether this man was diabetic and what his criteria are for making this diagnosis in such patients?

DR. GEORGE HAMWI: In essence I agree with Dr. Schieve. If this man had diabetes it certainly did not contribute to his demise. He had no

microaneurysms in the eyegrounds which occur in about 95 to 98 per cent of diabetic nephropathy. Therefore, I do not believe that he had any intrinsic metabolic degenerative disease which contributed to his renal condition.

QUESTION: How about periarteritis?

DR. SCHIEVE: I think it could well be. He did have hypertension and renal failure but he did not have any neuritis or anything else that would suggest this disease. When you have a man in chronic renal failure and have no idea of the size of his kidneys from any radiographic approach, it has to remain partly a simple guessing game. It is always hard to know whether a patient with chronic uremia should have a retrograde pyelogram or not. Our patient could have had obstructive uropathy that we do not know about because we never investigated it.

QUESTION: Do you see an identical picture in very acute glomerulonephritis?

DR. SCHIEVE: I think you could see the entire clinical picture in acute glomerulonephritis. The reason I did not make this diagnosis is that I have never seen such a low hemoglobin in acute glomerulonephritis.

Clinical Diagnosis

1. Chronic glomerulonephritis.
2. Uremia.
3. Mild diabetes mellitus.

Pathological Diagnosis

1. Chronic glomerulonephritis.
2. Bronchopneumonia.
3. Uremia.

Pathological Discussion

DR. BLOODWORTH: The gross autopsy showed a well-developed Negro man in a good state of nutrition. No fluid was present in any of the cavities. The heart was enlarged and showed marked thickening of the left ventricle. Both lungs appeared quite edematous and showed some dark gray nodules. The liver weighed 2000 grams and appeared firm and smooth. The pancreas was grossly normal. The gastrointestinal tract was not remarkable. The adrenals were enlarged and weighed 17 grams. The kidneys appeared to be only slightly decreased in size; they were pale and finely granular; no scars were noted. There was poor demarcation between the cortex and medulla. The larger renal vessels did not show any appreciable degree of arteriosclerosis. The bladder, prostate and ureters appeared normal.

Microscopic Examination

Sections from the lungs showed areas of bronchopneumonia with some bacterial colonies. In addition, areas were noted in which the alveoli

were filled with fibrin and red blood cells, lesions which are commonly observed in uremia. Sections from the pancreas and liver appeared normal and did not show any changes commonly found in diabetes. Sections from the adrenals showed severe cortical hyperplasia. Sections from the parathyroids also showed nearly all the fat replaced by highly active chief cells. The bone marrow appeared hyperplastic.

Sections through the stomach showed a uremic gastroenteritis. Sections from the kidneys showed nearly all glomeruli involved in a sclerosing process. Some glomeruli showed endothelial proliferations with crescent formation and intracapsular adhesions and only a few glomeruli appeared uninvolved. The tubules were decreased in number and some of them were filled with protein casts. The interstitial reaction was minimal. The lesion is typical of a terminal chronic glomerulonephritis, and there was no histological evidence of diabetic nephropathy, pyelonephritis or nephrosclerosis.

The diagnosis then agreed fully with that made by the clinician, and we feel that the patient died from extensive renal damage due to chronic glomerulonephritis with uremia. His bronchopneumonia was a terminal development.

Evaluation of Gastric Analysis Without Intubation

Several modifications of the tubeless gastric analysis were evaluated in duodenal ulcer patients and in normal controls. The results were compared to those obtained with a standard intubation test (Ewald). Neither the Ewald nor the tubeless tests appeared sufficiently accurate to be clinically helpful in distinguishing ulcer patients from normals. It seems probable that gastric analysis can provide diagnostically useful information in patients with duodenal ulcer only if one of the more precise intubation technics is employed.—Casimir A. Domz, M. D., and Cleopha L. Hoag, B. A., Santa Barbara, Calif.: *Am. J. Gastroenterology*, 31:432, April, 1959.

Medical Investigation of Suicide

More attention should be given to the medical investigation of suicide. In the future this form of violent death will assume added importance. Sooner or later it will become a matter of public concern.

The physician interested in forensic medicine can become adept at this type of investigation. In making his specialized knowledge and trained investigative mind available to the law enforcement agencies he performs a valuable service to the community.—Robert Hausman, M. D., San Antonio: *Texas State J. Med.*, 55:43, January, 1959.

Ohio Medical Indemnity . . .

Board of Directors and Officers Elected at Annual Meeting Held on April 29; Review of Past Year's Accomplishments Presented in Reports

ANNUAL meeting of the shareholders of Ohio Medical Indemnity, Inc., was held at the home office building in Columbus on Wednesday, April 29.

Nominations from The Council of the Ohio State Medical Association for membership on the Board of Directors were received by the shareholders and at the official election the following were re-elected to the board for the ensuing year:

Members of Board

Perry R. Ayres, M. D., Columbus; H. M. Clodfelter, M. D., Columbus; D. W. English, M. D., Lima; Charles N. Hoyt, M. D., Chillicothe; Robert S. Martin, M. D., Zanesville; J. Stewart Mathews, M. D., Wyoming; George L. Sackett, M. D., Cleveland; L. Howard Schriver, M. D., Cincinnati; Robert G. Smith, M. D., Circleville; Gordon M. Todd, M. D., Toledo; Edmond K. Yantes, M. D., Wilmington; Starling C. Yinger, M. D., Springfield; Clair E. Fultz, Columbus; Fred D. Learey, Columbus; Msgr. Robert A. Maher, Toledo; Harold W. Slabaugh, Akron, and David L. Temple, Dayton.

New members elected to the Board were: Frank L. Shively, Jr., M. D., Dayton; Stanley R. Mauck, Columbus; John F. Schoedinger, Columbus; and Edgar O. Mansfield, Columbus.

Those retiring from the Board were: Dr. R. Dean Dooley, formerly of Dayton, who is now full-time director of the OMI Department of Professional Relations; David A. Endres, Youngstown; Richard M. Ross, Columbus; and James V. Walker, Columbus.

Officers Elected

At the Annual Meeting of the Board of Directors following the shareholders meeting, the following officers for the ensuing year were elected: President, Dr. Clodfelter; vice-president, Dr. Yantes; executive vice-president, Charles H. Coghlan, Columbus; secretary-treasurer, Charles S. Nelson, Columbus; assistant secretary-treasurer, Frank W. Van Holte, Columbus. Mr. Wayne E. Stichter, Toledo, was elected legal counsel.

President Clodfelter appointed the following as members of the Executive Committee: Dr. Yantes, chairman, Mr. Fultz, Dr. Hoyt, Dr. Martin, Dr.

Sackett, Dr. Smith, Mr. Slabaugh, Dr. Yinger and Dr. Shively.

Reports on Year's Activities

Reports presented to the shareholders and the Board by the administrative and various committee chairmen included the following information:

On December 31, 1958, OMI completed its thirteenth year, having been organized in the Spring of 1945. The first subscriber's contract became effective in January, 1946.

On December 31, 1958, OMI had 928,445 contracts in effect, covering 2,302,739 persons. During 1958, the company had a net growth of 7,556 contracts, covering 18,175 persons. OMI is the fourth largest Blue Shield plan in the United States, the leaders being New York City, Pennsylvania and Michigan.

Paid 343,772 Claims

OMI returned 84.95 per cent of each income dollar to subscribers in the form of claim payments in 1958, an increase of 3 per cent over the year 1957. During 1958, the company paid 343,772 claims—an average of 1,353 claims for each working day, representing an expenditure of \$73,700 per day. During the year, OMI paid out in claims a total of \$18,890,000. At the end of the year it had approximately \$13,000,000 in its general reserve fund.

New Contract Launched

During 1958, the company developed and launched its new Major Contract; decided to discontinue sale of the old Standard Contract; established the new Department of Professional Relations under the direction of Dr. Dooley; and liberalized all contracts by including certain specific surgical services when performed by dentists and chiroprodists as well as physicians.

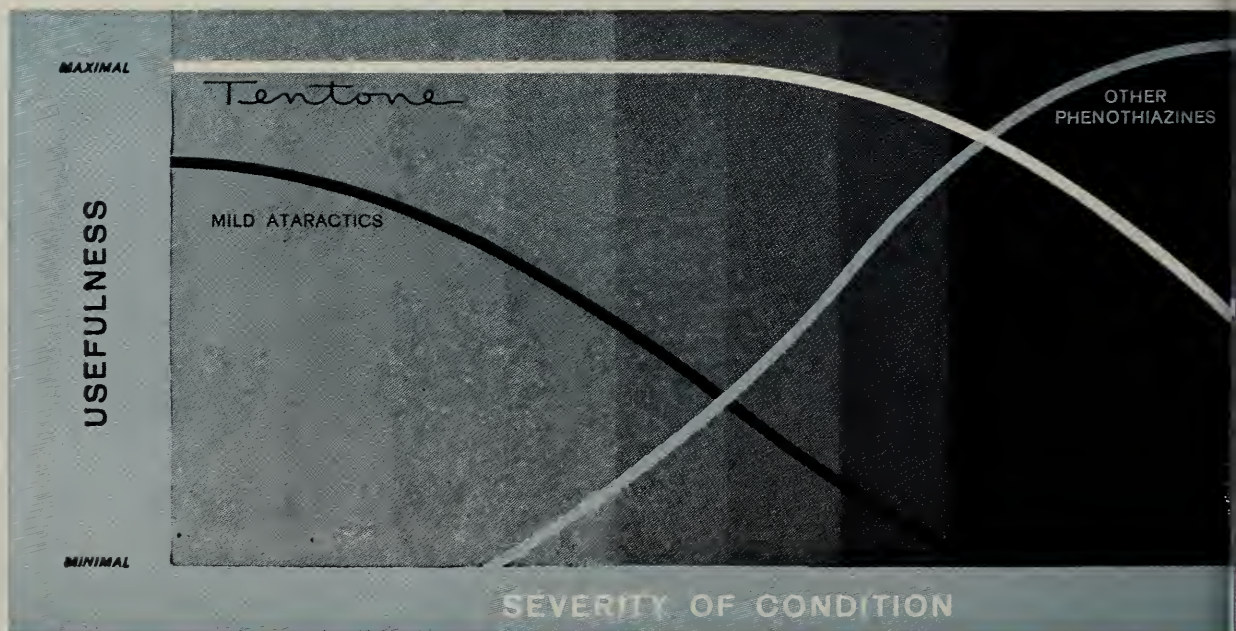
AMA Archives of Neurology and Psychiatry To Be Separated

Two new AMA specialty journals will replace the *AMA Archives of Neurology and Psychiatry*, beginning in July.

The boards which guided the two sections of the old journal will direct the two new journals. Dr. Howard G. Wolff, New York, is editor of the neurology board; Dr. Roy F. Grinker, Sr., Chicago, the psychiatry board.

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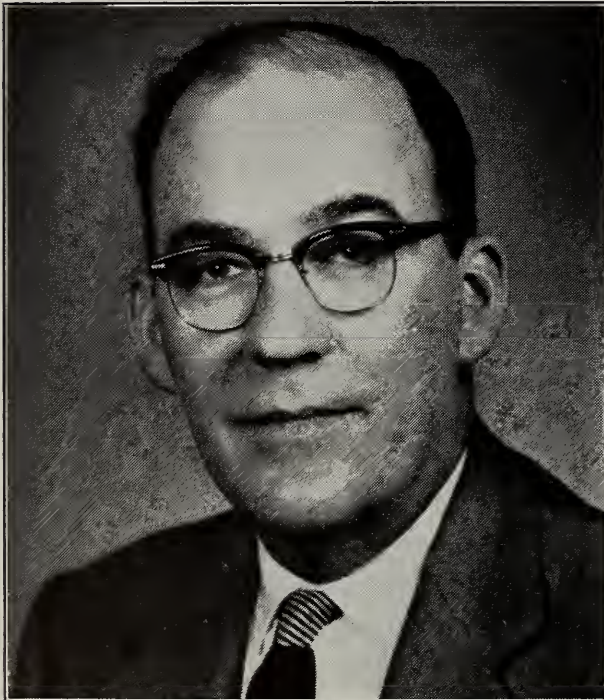
Presenting . . .

The New President-Elect and Four New Councilors Elected by the House Of Delegates in Columbus, with Information on Other Council Members

THE HOUSE OF DELEGATES named a President-Elect and four new Councilors at the Annual Meeting in Columbus, April 21-24. Following are biographical sketches of these new officers as well as information about other members of The Council.

Dr. Edwin H. Artman, Chillicothe, was named President-Elect of the Association after serving six years as Councilor for the Tenth District. He will assume the Presidency at the 1960 Annual Meeting in Cleveland.

Dr. Artman comes to the high office in the Association after a succession of responsible positions in medical organization work. A practicing physician in Ross County since the completion of his internship, he was chief of staff at the Chillicothe Hospital in 1948 and 1949 and president of the Ross County Academy of Medicine in 1950 and 1951. Elected an alternate delegate to the American Medical Association in 1952 by the OSMA House of Delegates, he was named Councilor of the Tenth District the following year.



Edwin H. Artman, M. D.

A native of Portland, Indiana, he has lived most of his life in Ohio. The family moved to Piqua where he graduated from Piqua High School in 1928. His college work was at Ohio State University where he received a Bachelor's Degree and went on to graduate from the OSU College of Medicine in 1935. Internship followed at White Cross Hospital in Columbus.

He began his practice in Kingston, a town in northeastern Ross County, later taking courses in anesthesiology at the New York Postgraduate School and Hospital returning to Ross County where he established his practice in Chillicothe. He is in general practice with special interest in anesthesia.

During World War II, he served four years in the U. S. Army Air Force, Air Transport Command, first as flight surgeon in the Arctic and later completing his military active duty as commanding officer of the Morrison Field Hospital, West Palm Beach, Florida. While in the

service, he attended the School of Tropical Medicine at the Army Medical Center, Washington, D. C., the School of Malariology at Panama City, Panama, and the School of Aviation Medicine, Randolph Field, Texas.

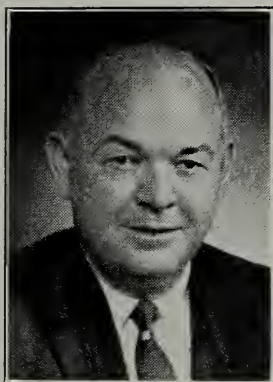
Professional affiliations include membership in the American Society of Anesthesiology, the American Academy of General Practice and the American Medical Association. He is also active in a number of civic and fraternal organizations; has served as director of health for the Ross County Civil Defense Program and as a member of the Board of Directors of the Ross County Polio Foundation. A member of the Chillicothe Chamber of Commerce, he formerly was first vice-president of that organization. He is a Mason, a member of the Elks Lodge, the Kiwanis Club, the Presbyterian Church and is on the Personnel Board of the City of Chillicothe.

Doctor Artman is married and has two sons.

Incoming President

Dr. Frank H. Mayfield, Cincinnati, assumed the office of President of the Association at the final meeting of the House of Delegates.

Dr. Mayfield is a practicing physician in the field of neurological surgery. He was named President-Elect at last year's Annual Meeting after serving as Councilor of the First District. His other services to the State Association include those as chairman of its Committee on Public Relations and Economics and as chairman of the Subcommittee on Legislation. A former President of the Academy of Medicine of Cincinnati, he has held numerous offices and committee appointments in that Society.



F. H. Mayfield, M. D.

Dr. Mayfield is a diplomate of the American Board of Neurological Surgery and now serves as member of that examining board representing the surgical section of the American Medical Association. He is assistant professor of clinical surgery in the University of Cincinnati College of Medicine, on leave to serve as a member of the Board of Directors of that University. He is Director of the Department of Neurosurgery at The Christ and Good Samaritan Hospitals in Cincinnati and on the attending or consulting staffs of many other Cincinnati hospitals as well as those of neighboring cities.

Nationally, Dr. Mayfield has held several positions of high responsibility. A Fellow of the American College of Surgeons, he is a former member of its Board of Governors, a member of the Committee on Trauma and former chairman of the Subcommittee on Crash Injury Prevention. He is Past-President of the American Academy of Neurological Surgery, a member of the Society of Neurological Surgeons, a Fellow of the American Association for the Surgery of Trauma and a member of its Board of Managers. He has served as vice-chairman of the Section on Nervous and Mental Diseases of the American Medical Association.

During World War II, Dr. Mayfield served from August, 1942, to February, 1946, in the Army Medical Corps. With the rank of Lieutenant-Colonel, he served as chief of the Neurological Surgery Section, Percy Jones General Hospital, Battle Creek, Michigan, a U. S. Army Hospital. At present he is area consultant in neurosurgery for the Veterans Administration.

Dr. Mayfield is a native of Garnet, South Caro-

lina, and earned his degree as Doctor of Medicine in the Medical College of Virginia, Class of 1931. He took his internship at the Hospital Division of the same college and went immediately into residency training in neurosurgery. In 1935 he accepted an appointment as instructor in neurosurgery at the University of Louisville School of Medicine and the following two years was assistant to Dr. R. Glen Spurling, Louisville neurologist and medical educator.

Dr. Mayfield is married, has four children and one grandchild.

Second District Councilor

Dr. Ray M. Turner, Springfield, was elected Councilor for the Second District to succeed Dr. R. Dean Dooley, who has accepted a full-time position with Ohio Medical Indemnity.



R. M. Turner, M. D.

A native of Springfield, Dr. Turner has been in practice there since 1936 and has an excellent background of experience in medical organization work. A graduate of Ohio State University College of Medicine in 1935, he took intern training at Springfield City Hospital and began general practice the following year. In 1938 he

went to Minneapolis, Minn., for a preceptorship in proctology and remained there until 1942. Military service followed, from 1942 to 1945, during which he was a medical officer with the Air Force. Since his return to Springfield in 1946 he has limited his practice to proctology.

Dr. Turner is chief of the Proctologic Department, City and Mercy Hospitals and consultant in proctology at Rickley Memorial Hospital and at Clark County Tuberculosis Sanatorium. He is Associate Fellow, American Proctologic Society and Fellow of the International College of Surgeons; also president of the Ohio Valley Proctologic Society.

A past-president of the Clark County Medical Society, he has been delegate of that Society to the OSMA House of Delegates since 1946. He is a past-president of the Springfield Development Council and district trustee for the Ohio Division of the American Cancer Society.

Dr. Turner married Lillian Posch Turner who also received an M. D. degree from Ohio State in

1935. The Turners have two sons, John, 16, and Jeff, 12.

Fourth District Councilor

Dr. W. W. Green, Toledo, was elected Councilor of the Fourth District to succeed Dr. Paul F. Orr who had served the maximum of three terms on The Council. Dr. Green has been a practicing physician in Toledo since the completion of his specialty training. He limits his practice to proctology.



W. W. Green, M. D.

Active in professional circles, he is a past-president of the Academy of Medicine of Toledo and Lucas County, has served on the Academy's Board and Council and has been a member and chairman of numerous local committees. He has served in the OSMA House of Delegates as representative of the Toledo Academy.

A diplomate both of the American Board of Proctology and the American Board of Surgery, he is a past-president and former secretary of the American Proctologic Society. Professional appointments include those as senior attending surgeon and director of proctology, St. Vincent's Hospital; senior attending surgeon, the Toledo Hospital, and honorary staff, Maumee Valley Hospital. He is a member of the editorial board of *Diseases of the Colon and Rectum*, published by J. B. Lippincott Company.

A native of Cincinnati, Dr. Green graduated from the University of Cincinnati College of Medicine in 1928. He took his internship at St. Vincent's Hospital, Toledo, and stayed there for a year of residency training. He then went to New York where he continued his residency training at New York City Hospital. During World War II, he served with the Army Medical Corps from 1942 to 1944.

Local affiliations include memberships in the Rotary Club and the Toledo Club. Previous positions held in civic organizations include those as trustee of the Maumee Valley Country Day School; trustee, Toledo Chamber of Commerce; trustee, Maumee Valley Medical Advancement Trust; trustee, Academy of Medicine Education Foundation.

Dr. Green is married and the father of two children. A married daughter, Sarah Ellen Abel is in Yohosuka, Japan. His son, Willard Poole Green is graduating from Haverford College this year and will enter Yale Divinity School in the fall.

Sixth District Councilor

The House of Delegates elected Dr. Robert E. Tschantz, Canton, as Councilor of the Sixth District, to succeed Dr. Carl A. Gustafson, who had served the maximum of three terms in that office.



R. E. Tschantz, M. D.

A native of Canton and practicing physician there since 1946, Dr. Tschantz's interest in organized medicine dates from that same year. He has served on numerous committees of the Stark County Medical Society, held every office in the local group and became its president in 1956. He also has served as president of the Canton Academy of Medicine, an organization of physicians of that city.

He has served on several State Association committees, has been a member of the OSMA House of Delegates and is a former secretary of the Sixth Councilor District organization.

Dr. Tschantz received his pre-medical education at Denison University, Granville, and attended the University of Cincinnati College of Medicine from which he received his M. D. degree in 1940. An internship followed at Akron City Hospital and a residency in internal medicine at Youngstown Hospital Association.

From 1942 to 1946 he was with the Army Air Force, performing medical services in this country and overseas, one year as flight surgeon. He attained the rank of major.

In the practice of internal medicine, he is on the senior attending staff of Aultman Hospital, has been chairman of its Medical Department for four years, and is on the courtesy staff at Mercy Hospital.

Dr. Tschantz is married and the father of two children, Susan 16 and Bob 13. He is a member of the Evangelical and Reformed Church, a member of the Rotary Club and is on the board of the Hospital Bureau and the YMCA Boy's Camp. He has a unique hobby, that of precious stone cutting, and enjoys a good golf game and fishing trip.

Tenth District Councilor

Dr. Robert M. Inglis, Columbus, was elected Councilor of the Tenth District to succeed Dr. Artman.

Dr. Inglis specializes in obstetrics and gynecology. A graduate of Ohio State University College of Medicine, Class of 1938, he served

his internship at St. Luke's Hospital in Cleveland and took residency training in his specialty at White Cross Hospital, Columbus, where he is now chairman of the Obstetrics and Gynecology Department. A diplomate of the American Board of Obstetrics and Gynecology, and a Fellow of the American College of Obstetrics and Gynecology,



R. M. Inglis, M. D.

he is this year's president of the Columbus Obstetric and Gynecologic Society. He is also instructor in obstetrics and gynecology at the OSU College of Medicine.

Medical organization activities are numerous. He is a past-president of the Columbus Academy of Medicine, having served in the capacity as presi-

dent in 1958. He has served on numerous committees of the local Academy and has been in the OSMA House of Delegates for several terms.

Local activities extend to many civic organizations. He was president of the Metropolitan Health Council in 1954 and is a past-chairman of the Medical Division of United Appeals and has served on the Board of Directors of Friendship House and the Volunteers of America. Other local affiliations include the Rotary Club, the University Club and the Columbus Country Club. During World War II, he served as medical officer with the Navy from 1944 to 1946.

Dr. and Mrs. Inglis are the parents of four children. Dr. Inglis is the son of Dr. William D. Inglis, now retired after practicing for many years in Columbus.

Other Members of the Council

Dr. George A. Woodhouse, Pleasant Hill, as immediate Past-President, will serve an additional year on The Council.

Dr. William D. Monger, Lancaster, was re-elected Councilor of the Eighth District. Dr. Monger was elected in 1956 to fill one year of an unexpired term and was elected in 1957 to his first full term.

Councilors in the midst of two-year terms are: Dr. Charles W. Hoyt, Cincinnati, First District; Dr. Floyd M. Elliott, Ada, Third District; Dr. George W. Petznick, Cleveland, Fifth District; Dr. Robert E. Hopkins, Coshocton, Seventh District; Dr. Carter L. Pitcher, Portsmouth, Ninth District; and Dr. H. T. Pease, Wadsworth, Eleventh District. Dr. Geo. J. Hamwi, Columbus, is serving a three-year term as Treasurer.

Cincinnati Academy Is Sponsor of Traffic Safety Panorama

The Academy of Medicine of Cincinnati, with the cooperation of 16 other organizations, sponsored a Traffic Safety Panorama May 2 and 3 in the University of Cincinnati Field House.

The panorama was staged for benefit of the public, and included two programs featuring outstanding speakers, demonstrations and some of the latest exhibits in the traffic safety field.

Participating in the program which marked the opening of the show were OSMA President Mayfield, Dr. J. Robert Hudson, president of the Academy; University of Cincinnati Vice-President Ralph C. Bursiek, Judge Otis R. Hess, past-president, Greater Cincinnati Safety Council; Hamilton County Juvenile Judge Benjamin S. Schwartz, Ohio Department of Highway Safety Director J. Grant Keys, and John O. Moore, Ph. D., director, Cornell University crash injury research.

The Academy also presented Sunday evening in the form of a regular academy meeting for benefit of the public a scientific session in which Dr. Moore spoke on "Crash Injury Prevention." Dr. Moore was presented by Dr. N. J. Giannestras, Cincinnati, chairman of the OSMA Traffic Safety Committee.

Cooperating with the Academy were the Greater Cincinnati Safety Council, Cincinnati Public Schools' Division of Health and Hygiene, Cincinnati Area Red Cross Chapter, City of Cincinnati police, health, engineering, and traffic engineering divisions; OSMA and its Traffic Safety Committee; Ohio Department of Highway Safety, Ohio Highway Patrol, Hamilton County Sheriff's office, Ohio State Safety Council, Ohio Committee on Trauma, American College of Surgeons; Cincinnati Automobile Club, and the University of Cincinnati.

The panorama included more than 20 exhibits related to traffic safety, many movies on the subject and demonstrations by the Cincinnati Fire Division's Life-Saving Squad.

In addition to exhibits by the Academy and cooperation groups, exhibits also were displayed by the Cincinnati Board of Education, Mack Volunteer Fire Department, Cincinnati Parts Association, Ohio State Rangers, Ford Motor Company and the Aetna Life Insurance Company.

Chairmen of the special committees for the meeting were Dr. Samuel A. Trufant, arrangements; Dr. Curwood R. Hunter, program; Dr. Eugene P. Fromm, attendance; Dr. Neal N. Earley, exhibits, and Dr. Charles D. Buhl, publicity. Edward F. Willenborg, Academy executive secretary, was coordinator.

Address of the President . . .

Retiring Head of the Association Presents His Views Before the First Session of the House of Delegates at the Annual Meeting on April 20

By GEORGE A. WOODHOUSE, M. D., Pleasant Hill, Ohio

THIS House of Delegates is the most important and most representative group within the Ohio State Medical Association. For that reason, members of the House of Delegates can be most influential in getting the component county medical societies to give their active support to the varied programs and projects of the State Association. I hope you will accept this as one of your major responsibilities.

In order to carry out this assignment, members of the House of Delegates must be more than just aware of the activities of the Association. They must be well-informed. In addition, they must be personally interested.

That being the case, I would like to summarize for you some of the major events and developments of the past twelve months during which I have had the privilege of serving as president of our Association.

Corporate Practice

Shortly after I succeeded Dr. Robert Martin as President, The Council gave its unanimous approval to a report on the subject of unauthorized practice of medicine by partnerships, associations, institutions, corporations and unlicensed persons.

This report was submitted jointly by the Association's Judicial and Professional Relations Committee and the Committee on Hospital Relations. It was the result of many hours and days of study and conference with many groups within and outside of the medical profession. The study has been requested by the House of Delegates in 1957.

The Association may rightfully be proud of this fine report. It has been acclaimed by many as an exceptionally searching analysis of the question. It summarizes court cases, judicial opinions, opinions of Ohio's attorney general, statements on the ethical aspects issued by the Judicial Council of the AMA, and actions of the AMA House of Delegates, and our own House of Delegates. It has been referred to as a clear and definite guide for action which may be taken or contemplated by county medical societies against those who violate ethical tenets.

I strongly recommend that our county societies review carefully this report on corporate practice.

They should make use of it whenever the occasion demands.

New Committees

At the 1958 Annual Meeting, the House of Delegates took actions which necessitated the appointment of four new committees, namely: Committee on Poison Control, Committee on Traffic Safety, Committee on Laboratory Medicine, and Committee on Care of the Aged. These committees have been extremely active during the past year. I would like to review briefly their work.

Committee on Poison Control

The Committee on Poison Control was set up for the purpose of:

(1) Studying plans for the establishment of a single Central Poison Control Center for Ohio.

(2) Initiating a state-wide educational program on prevention of accidental poisoning.

(3) Studying the need for additional legislation in Ohio for accurate and uniform labeling of products as to content, etc.

(4) Securing of cooperation of hospital and pharmaceutical associations, drug manufacturers, safety councils, health departments and other interested groups in order to develop support for a comprehensive, state-wide poison control program.

The committee has reported to The Council that it believes it would not be feasible to try to establish a single state poison control center at this time. The Council has concurred in this decision. The reasons presented by the committee are set forth in a special report which will be presented to this House of Delegates later in this session.

The committee is cooperating with six area poison centers. Their locations and telephone numbers are published each month in *The Ohio State Medical Journal* for the information of physicians. They should be called upon for advice and information in cases of emergency. Efforts to strengthen these regional centers will be undertaken.

Informative articles on the subject of poison control, especially the medical aspects, have been appearing in *The Journal*. More are being prepared.

The committee has been meeting with represen-

tatives of other organizations and with representatives of official agencies. At these meetings ways of working together on poison control problems have been discussed. Also, a study is being made as to the need for a stronger state poison control law and, if so, what the provisions of that law should be.

We have here a hard working committee dealing with a vitally important subject—one which should be of great interest to all the people of Ohio. It is another demonstration of the willingness of the medical profession to give much time and effort to activities designed solely to protect the health and well-being of the public.

Traffic Safety Committee

Our new Traffic Safety Committee has been quite active. Some of the major activities of this committee have been:

Cooperation in the Cornell Crash Injury Program in Ohio which is a three-year study of passenger-car accidents in certain areas of Ohio;

Production of a handbook and guide for Traffic Safety Committees of our county medical societies;

Sponsoring of a special session on trauma at this Annual Meeting and a special exhibit in the Scientific and Educational Exhibit;

Cooperation with the Ohio Trauma Committee, American College of Surgeons, in its efforts to establish and promote minimum standards for emergency room care in hospitals and in physicians' offices;

Plans for postgraduate courses in prevention, evaluation and treatment of traffic injuries, in cooperation with the Ohio Chapter, American College of Surgeons;

Plans for establishing liaison with state officials for the purpose of discussing questions involving physical standards and physical examinations of auto drivers, including school bus drivers and repeated traffic offenders.

Through the work of this committee, aided by the traffic safety committees of the county medical societies, the medical profession is making a real contribution to state-wide efforts to reduce the high rate of traffic accidents and to raise the standards of care given to those who are accident victims.

I hope that the traffic safety committees in each county medical society will carry on an active program, supplementing the work of the state committee.

Committee Laboratory Medicine

You will recall that the House of Delegates in 1957 requested a study of ways to improve the standards and quality of clinical laboratory work available to Ohio physicians. A special subcom-

mittee of the Committee on Public Relations and Economics made a survey of 238 Ohio laboratories.

The subcommittee submitted various recommendations, including one that the Association have a permanent Committee on Laboratory Medicine to put into effect the suggestions of the special subcommittee.

Shortly after taking office, I appointed a Com-



Dr. George A. Woodhouse gives the "President's Address" during the first session of the House of Delegates.

mittee on Laboratory Medicine. This committee has come a long way in a short time.

One of its first projects was to undertake sponsorship of the Conference on Laboratory Medicine which will be held Thursday morning as a part of this Annual Meeting program.

More recently the committee held a meeting with representatives of the Ohio Hospital Association to consider ways of improving the quality of laboratory services in Ohio. At that meeting, the following program was considered:

1. A survey of Ohio hospitals to ascertain the extent of pathologist coverage.
2. Encourage hospitals with full-time pathologists to permit those pathologists to devote part of their time for consultation with smaller hospitals.
3. Emphasize desirability of utilization of properly trained technologists when available.
4. Continual recruitment program for medical technologists.
5. Provide scholarship aid from local sources

and utilize county medical society woman's auxiliaries and other organizations in this effort.

6. Continuing education for technologists.

7. Encourage self-evaluation of hospital laboratories through participation in proficiency surveys now available and publication in *The Journal* once a year a list of laboratories participating in any of the recognized proficiency surveys.

8. Make available consultation to hospital laboratories, on request.

This is an ambitious program. If the committee makes it click, it will have chalked up a major achievement for the Association.

Health Care for Aged

The problem of providing health care for the aged is at the top of the action calendars of the AMA and our own Association. We have a new committee at work on this subject.

One of its first tasks was to establish close liaison with officials of the Division of Aid for the Aged. Discussions have been held with those officials on matters involving the medical fee schedule and the administrative rules of the Division's health care program. If the Division is successful in obtaining an appropriation from the present General Assembly, approximating the amount requested by the Division, there is reason to believe that the fee schedule which was in effect in 1956 will be restored and that many of the limitations on medical and hospital services will be repealed.

OSMA representatives will support the appropriations request before the General Assembly. If interested, you should discuss this matter with your representatives in the Legislature.

The committee has held several conferences with officials of the Ohio Association of Nursing Homes. A bill which that organization is sponsoring in the General Assembly received the endorsement of our committee. The measure would place administration of the licensing program for rest homes and nursing homes in the State Department of Health and would establish strict, but reasonable, standards for all such homes.

In mid-February of this year, the Committee on Care of the Aged sponsored a meeting in the Columbus Office for the purpose of discussing ways of setting up in Ohio a practical program of voluntary medical and hospital insurance for aged persons and at a cost within the means of our elder citizens.

That important meeting was attended, in addition to members of our own committee, by representatives of the Ohio Blue Cross Plans, Ohio Hospital Association, Ohio Medical Indemnity and Medical Mutual of Cleveland. All agreed

that Ohio must meet this challenge. All agreed to study the matter and prepare to offer definite suggestions for action at a meeting of the same group in the very near future. Personally, I am very hopeful that something definite and constructive will result from these conferences.

Let's take a detailed look at the factors underlying this problem—probably one of the most challenging confronting us.

It has been estimated that there are 14 million persons in this country over the age of 65 years. It has been predicted that this number will increase to about 20 million by 1965.

The Social Security Act and non-governmental retirement plans encourage persons to retire from gainful employment at the age of 65, thus magnifying the job of meeting the health needs of an increasing number of our citizens. Many of those who retire under the OASI program are finding the amount of their allowance inadequate, especially in these days of inflation. Some who are the beneficiaries of private retirement plans are able to get along fairly well until illness strikes.

Recently statistics were issued which would indicate that by 1965 we may expect an increase of 38 per cent in those under 21 years and an increase of 35 per cent in those over 65 years but only a 9 per cent increase in those between 21 and 65 years. Obviously, this means fewer people in the wage-earning bracket; fewer people to provide the means for expansion in our schools and for the care of our aged, including health care.

Ironically, this problem has developed as a result of the activities of the health professions, advances in the health and medical sciences and elevation of our economic standards.

Now we must assume our share of the responsibility for trying to find the answer to this problem which we have had a part in creating.

The Voluntary Way

Our voluntary medical and hospital care programs must be adjusted to make a place for those who are able to make modest premium payments from their fixed retirement income; and who desire to do so. Our efforts should be directed toward finding some way by which the employed will be able to build up equities in medical-hospital programs, to be used after retirement, with premium payments ending at retirement age.

The only alternative is government medicine—liberalization of present aid for the aged programs or inclusion of medical-hospital benefits as a part of the OASI program under Social Security—the Forand Bill.

I believe that most members of the medical profession would prefer to see the job done

through voluntary medical-hospital insurance plans or through other types of programs, sponsored and financed by employers, by employees, or by employers and employees jointly. Obviously, if we expect the retired to participate financially in these plans, the cost to them will have to be modest. By the same token, those supplying services—physicians and hospitals—will have to seriously consider adjusting their charges to the modest means of most of our aged citizens and to the moderate allowances which they will receive under their insurance or retirement plan coverages.

The problem is quite clear. The answer is complex and baffling.

We must do our best to find a solution within the framework of the private practice of medicine. This will require studious planning, great effort, and tolerance. I implore you to give the officers and Councilors of the Association, and the committee working on this, your earnest cooperation during the ensuing year.

Other Committee Activities

So far I have referred only to the work of new Association committees. Most of our old committees have had a busy year, also.

The Committee on Industrial Health and Workmen's Compensation has been split into two committees. That section of the committee relating to industrial health is planning a handbook for county medical societies on this subject; organization of a speakers' bureau; development of services through which it can act in an advisory capacity to local medical societies when industrial health problems arise locally; closer liaison with governmental agencies in this field and with other organizations interested in industrial health and industrial medical services.

Our Committee on Maternal Health, Committee on Rural Health and Committee on School Health have carried on their customary fine work during the past year.

Under the sponsorship of the Committee on Public Relations and Economics a standard, simplified health and accident insurance claim form has been developed for use by members of the Association who may wish to substitute it for forms supplied by insurance companies.

The Committee on Hospital Relations is continuing its fine relationship with the Committee on Professional Relations of the Ohio Hospital Association.

Several meetings have been held during the past year by the Committee on Mental Health. This committee plans to become more active.

The excellent program in store for us at this Annual Meeting reflects the excellent work of the Committee on Scientific Work.

Ohio Medical Indemnity, our Blue Shield Plan, continues to grow. It now covers 2,300,000 subscribers. During the past year, it has issued a new contract offering higher indemnities and covering additional services.

Organization Activities

There have been a number of special developments during the past year which should be brought to your attention.

The Council authorized approval of the Ohio State Society of Medical Assistants.

As you all know, Dr. Perry R. Ayres, Columbus, took over the duties of Editor of *The Journal* a few months ago, following the resignation of Dr. Forman. Please give Dr. Ayres your active support. We have one of the best journals in its field. Let's keep it at the top.

Last Fall the Association found it necessary to enlarge the Headquarters Office by renting adjacent footage in order to provide adequate space for the increased activities of the Association.

This is one reason The Council decided to ask the House of Delegates to increase the annual dues from \$25 to \$30. The many other logical reasons are set forth and documented in the statement which accompanies the resolution on this subject. It was sent to delegates and to County Medical Societies in advance of this meeting. I sincerely hope this House of Delegates will give this request for a \$5 increase in dues its unanimous support.

You will note from the progress report which will be presented to you later that the Association is studying the feasibility of setting up a mechanism for group participation by our members in a retirement-income program should the Keogh Bill become a law. Also, study is being made of the possibility of establishing a welfare (benevolent) fund through which aged needy physicians or the families of deceased physicians could be aided.

Another project which had been launched during Dr. Martin's term as president reached its maturity during the early months of my administration. I refer to our Group Life Insurance Program. This was based on studies and recommendations made by a committee composed of two of our past presidents—Dr. H. M. Clodfelter and Dr. C. C. Sherburne—and Dr. Roger Heering. It is an excellent program. It has been well received by many of our members, approximately 2,500 having enrolled so far.

Peering Into the Future

I shall not attempt to prognosticate what the future holds for the medical profession. This is covered in an excellent manner, in my opinion,

in the booklet, "The Health of the Nation," by Dr. Julian P. Price, Vice Chairman of the AMA Board of Trustees, a copy of which has been distributed to members of the House of Delegates. I am pleased that I had a part in helping Dr. Price assemble the material for that presentation.

As to the future—we may not like what we see or hear. If that is the case, it certainly would be suicide for us to turn our back to it. The challenge which confronts us is to try to guide and direct the changes which may come, despite our beliefs, in an effort to preserve high standards of medical care and maintain the private, competitive practice of medicine.

In Retrospect

Reflecting on the past two years, I find that I was called upon to visit many of our county medical societies; that it was necessary to attend many conferences in Ohio and in other states. I represented the Ohio State Medical Association at the annual meeting of each of the five surrounding state medical societies.

Many of these business gatherings were on Sunday which compels me to observe that should officials of the Ohio State Medical Association encounter difficulty when knocking at the Pearly Gates, it probably will be because they have been flagrant violators of the Fourth Commandment.

Yes, the job has meant many miles of travel and many hours away from home and practice. However, I have been repaid many fold. Many warm, lasting friendships have been won. It has been a thrill to witness that many of our county societies are facing up to their responsibilities. It has been satisfying to know that our Association ranks second to none in the nation in its over-all program of activities. It has been a pleasure to work shoulder to shoulder with so many dedicated to the purposes and objectives of our Association.

At this time, I should like to pay tribute to those on The Council and to those several hundred men on the Association committees, all of whom have devoted many days in carrying out their assignments.

Also, I want to commend the officers and committeemen of the various County Medical Societies for the work which they have been doing.

I would be accused of a grievous omission if I did not give substantial credit to our very efficient office staff, headed by Charles Nelson and his associates, G. H. Saville, Hart Page, Charles Edgar, and Gordon Moore, for their devoted work and efforts in the cause of organized medicine in Ohio. These men, together with the staff of women associates in our Headquarters Office make the organization run smoothly. Their hours are

long, their efforts are untiring, their results are reflected in the progress made each year by the Ohio State Medical Association.

Working closely with members of this OSMA team has been a rewarding experience. If I have been able to make some contribution to our Association, I am very happy. Again, my thanks to you for having given me the privilege of serving you. To those who will carry on, go my sincere best wishes. They will need the complete cooperation of every member of the Association, especially you who are among its leaders. Help them do the job!

Dermatologists File Protest With Editor of Time

At a meeting March 7, in Cincinnati, the Central States Dermatological Association formulated the following communication which was sent to the editor of *Time Magazine*:

"The Central States Dermatological Association, by unanimous action today (Saturday, March 7) at its annual meeting in Cincinnati, Ohio, attended by more than 150 qualified American Board Certified Dermatologists from their local Dermatological Societies of Cincinnati, Cleveland, Detroit, Buffalo, and Pittsburgh, protests and vigorously disapproves of *Time's* "Aftermath of Xrays" reporting (*Time*—February 23) of an article appearing in *The New England Journal of Medicine*, January 29, 1959.

"This association feels that *Time* has needlessly disturbed and alarmed countless thousands of persons who have had X-ray therapy for acne and other skin disturbances, administered by qualified dermatologists all over the United States, and that *Time* has failed completely in reporting the final, brief, and most important conclusion of the authors, namely: 'evidence gained from this study and those of others suggests that those not fully qualified in the therapeutic uses of x-rays be excluded from the application of this potentially dangerous tool.' "

Obstetrics and Gynecology

Applications for certification, American Board of Obstetrics and Gynecology, new and reopened, Part 1, and requests for re-examination Part II are now being accepted—deadline August 1.

Candidates are requested to write to the office of the Secretary for a current Bulletin. Application fee (\$35.00), photographs, and lists of hospital admissions must accompany all applications.—Robert L. Faulkner, M. D., Secretary, 2105 Adelbert Road, Cleveland 6, Ohio.

Annual Meeting in Review . . .

Presentation of Awards and Bestowing of Honors Are Among Highlights And Sidelights at Columbus Session; Picture Review Adds Graphic Touch

VOLUMES could be written on the efforts, procedures and happenings that went into a successful meeting. Following are only a few reports taken at random as examples of what transpired at the 1959 Annual Meeting in Columbus. Official reports of proceedings during the meeting are printed elsewhere under respective headings. The reader is referred to the inside front cover index for page numbers. Illustrations form an important part of this report and add many personal touches. Following are items of interest to members:

Honoring Past-Presidents

A social hour and dinner was given by The Council on Tuesday evening during the Annual Meeting, during which Past-Presidents of the Association, AMA Delegates, Annual Meeting Committee Chairman and Distinguished guests were honored. A photograph elsewhere shows Past-Presidents present for the occasion.

Plaques to Councilors

An innovation at this year's Annual Banquet was presentation of a plaque to Councilors who are terminating their office as Councilor of a district. President Woodhouse presented handsomely engraved plaques to Dr. Dean R. Dooley, who has resigned to accept a full-time position as director of professional relations for Ohio Medical Indemnity; and to Drs. Paul F. Orr, Carl A. Gustafson and Edwin H. Artman, each of whom has served the maximum of three full terms as Councilor.

Distinguished Guests

In addition to a number of out-of-state guest speakers who participated in the program, the Association was host to distinguished persons from neighboring states. Among guests at the Banquet and other functions of the meeting were the following:

Dr. Allen W. Crowley, president-elect of the Medical Society of the State of Pennsylvania, Harrisburg.

Dr. George F. Evans, president of the West Virginia State Medical Association, and Mrs. Evans.

Dr. Thomas O. Meridith, vice-president of the Kentucky State Medical Association, and Mrs. Meridith.

Dr. Kenneth L. Olson, president of the Indiana State Medical Association, and Mrs. Olson.

Dr. G. B. Saltonstall, president of the Michigan State Medical Society, and Mrs. Saltonstall.

James A. Waggener, executive secretary of the Indiana State Medical Association.

Mrs. Frank Gastineau, Indianapolis, president-elect of the Woman's Auxiliary to the AMA.

Mrs. Herbert C. McClelland, Lebanon, Pa., president of the Woman's Auxiliary to the AMA.

Dr. James S. Klumpp, Huntington, W. Va., past-president of the West Virginia Medical Association.

Mrs. Robert R. Pittman, Marlinton, W. Va., president-elect of the Woman's Auxiliary to the West Virginia Medical Association.

In the News

Press, radio and television coverage of the annual meeting was active, with seven writers from this media, plus cameramen, reporting on the sessions.

The reporters included Mary McGarey, *Columbus Dispatch*; Katherine Sullivan, *Columbus Citizen*; Edgar Barmann, *Ohio State Journal*; Hugh DeMoss, WLW-C-TV; Don Dunham, *Cleveland Press*; Severino P. Severino, *Cleveland News*. and Ray Bruner, *Toledo Blade*.

In addition, all news media in Ohio were provided with advance releases and follow-up releases of the meeting. Columbus news media and wire services were provided with running stories of the meeting, amounting to a morning release and an afternoon release Tuesday through Saturday morning.

AMA Lends a Hand

American Medical Association personnel as usual played some important roles in the OSMA Annual Meeting. Two AMA staff members participated in the program and two others installed and manned booths in the Scientific Exhibit.

Warren E. Whyte, attorney in the Law Division of the AMA office in Chicago, moderated the panel discussion on "Food Faddism."

Oliver Field, director of the AMA Bureau of Investigation, was a member of panel on "Food Faddism."

Howard Schulz, of the AMA Exhibit Department, was present throughout the meeting to man

Tops in Entertainment—and All by M. D.'s



An all-time high in entertainment was furnished at the Annual Banquet by the Montgomery County Medical Society Glee Club. Here Dr. W. J. Lewis is directing one of the selections, each one of which led to a more hearty ovation from the audience.

the AMA exhibit "Physician's Responsibility in Highway Accidents." He was assisted by physicians of the Columbus Academy.

Miss Mary Jane Kibler, a member of the AMA Food and Nutrition service, also was present throughout the meeting to take charge of the AMA exhibit, "Nutrition Nonsense and Food Quackery."

Future Annual Meetings

Dates and places for future OSMA Annual Meetings are as follows: 1960, week of May 15, Cleveland; 1961, week of April 16, Cincinnati; 1962, week of May 13, Columbus; 1963, week of April 21, Cincinnati; 1964, week of April 26, Columbus.

Exhibit Awards

The array of Scientific Exhibits was one of the points of interest at the Annual Meeting. Hundreds of physicians took their turns manning the various exhibits and answering questions as physicians and visitors stopped to investigate.

A committee appointed for the purpose scanned the exhibits and singled out seven for outstanding achievement. Special awards were announced as follows:

Gold Award in Medical Teaching—The exhibit, "Steering Wheel Injuries of the Chest,"

sponsored by Drs. William G. Pace, Charles V. Meckstroth, William Milnar and Karl P. Klassen, Division of Thoracic Surgery, Department of Surgery and Department of Radiology, Ohio State University.

Gold Award in Original Medical Investigation—The exhibit, "Surgery of Acquired and Congenital Heart Disease," sponsored by Drs. Earl B. Kay, David Mendelsohn and H. A. Zimmerman, St. Vincent Charity Hospital, Cleveland.

Silver Award in Medical Teaching—The exhibit, "Perforated Peptic Ulcers," sponsored by Drs. Richard W. Zollinger and Carlos Andarsio, Mount Carmel Hospital, Columbus.

Silver Award in Original Medical Investigation—The exhibit, "Exclusion of Paternity by Blood Antigen Studies," sponsored by Drs. John W. King and Thomas O'Mara, Cleveland Clinic.

Bronze Award in Medical Teaching—The exhibit, "Air Embolism," sponsored by Drs. John R. Jones, L. T. Franklin, Jay J. Jacoby and John B. Ziegler, Department of Anesthesia, University Hospital, Columbus.

Bronze Award in Original Medical Investigation—The exhibit, "Problems of Sex Determination," sponsored by Drs. Lester W. Martin, William K. Schubert, Virginia M. Esselborn and Ben-

jamin H. Landing, University of Cincinnati College of Medicine and Children's Hospital, Cincinnati.

A Certificate of Merit was awarded to the exhibit, "Maternal Mortality in Franklin County—A 10 Year Study; Maternal Health in Ohio—the OSMA State Study," sponsored by Dr. Richard L. Meiling and Anthony Ruppertsberg, Jr., the Columbus Obstetric-Gynecologic Society and Committee on Maternal Health, Ohio State Medical Association.

A Special Award was presented to the exhibit "Restoration of Pinch in the Severely Injured Hand," sponsored by Dr. John C. Kelleher and Dr. James G. Sullivan, Toledo.

Officers of Scientific Sections

Specialty Sections of the Ohio State Medical Association, which are responsible for planning programs for the Annual Meeting, held brief business meetings in addition to their programs and elected or re-elected officers for the coming year. These officers are as follows:

Section on Anesthesiology—Charles W. Hoyt, Cincinnati, chairman; Reynold M. Crane, Cleveland, secretary.

Section on General Practice—Burt E. Schear, Dayton, chairman; Pearl O. Staker, Mansfield, secretary.

Section on Industrial Medicine—Paul A. Davis, Akron, chairman; Charles E. Work, Cincinnati, secretary.

Section on Internal Medicine—Henry W. Ryder, Cincinnati, chairman; Leonard Lovshin, Cleveland, secretary.

Section on Nervous and Mental Diseases—Arnold Allen, Dayton, chairman; E. H. Crawfis, Cleveland, secretary.

Section on Neurological Surgery—Nathaniel Hollister, Dayton, chairman; William E. Hunt, Columbus, secretary.

Section on Obstetrics and Gynecology—Edward Eichner, Cleveland, chairman; James M. McCord, Cincinnati, secretary.

Section on Ophthalmology—Barnet R. Sakler, Cincinnati, chairman; James E. Bennett, Cleveland, secretary.

Section on Otorhinolaryngology—Richard H. Stahl, Cuyahoga Falls, chairman; A. L. Peter, Akron, secretary.

Section on Pediatrics—Charles Q. McClelland, Cleveland, chairman; Charles Robert McClave, Columbus, secretary.

Section on Physical Medicine—Paul A. Nel-



Dr. Robert S. Martin (left), Immediate Past-President, is shown presenting Dr. George A. Woodhouse an engraved tray as a symbol of appreciation from the Association for a year of service well done. Mrs. Woodhouse is seated at the right.

son, Cleveland, chairman; Leo Rosenberg, Dayton, secretary.

Section on Radiology—Carroll Dundon, Cleveland, chairman; Daniel E. Wertman, Cleveland, secretary.

Section on Surgery—Jack W. Cole, Cleveland, chairman; Ralph W. Lewis, Portsmouth, secretary.

Section on Urology—G. E. Horton, Springfield, chairman; Jack N. Taylor, Columbus, secretary.

Medical College Celebrates

A fitting finale to the 1959 Annual Meeting was furnished by the Ohio State University College of Medicine. A joint committee of the two groups worked out a program whereby the College of Medicine sponsored the Friday program of the Association as part of its 125th Anniversary celebration. Additional features of the anniversary were held on the campus the following day and on Sunday morning.

Alumni who have made their marks in all parts of the country, as well as Medical College faculty, participated in the Friday program. Out-of-state guest speakers' pictures were published in the program.

On Friday students of all medical classes visited the exhibits at the Veterans Memorial Building and heard postgraduate lectures by alumni and faculty. Many alumni of the College also were in Columbus to attend functions.

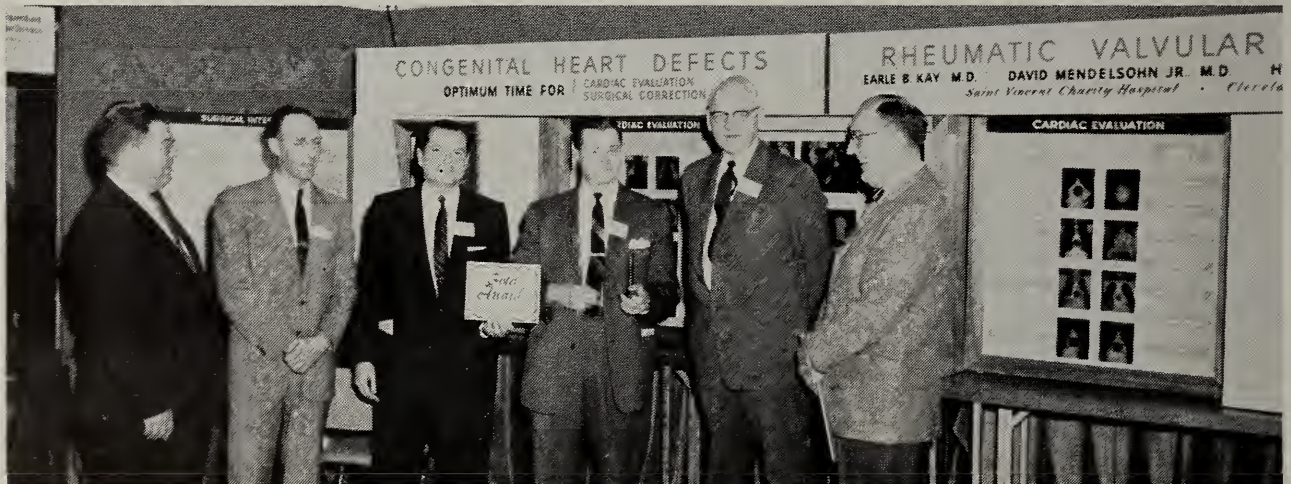
Classes of the Medical College which combined their reunion meetings with the anniversary cele-

(Continued on Page 833)

These Scientific Exhibits Chosen for Awards



Members of the special committee appointed to evaluate the exhibit are shown here presenting the Gold Award in the field of medical teaching to a sponsor of the exhibit on "Steering Wheel Injuries to the Chest." Left to right are: Dr. Charles W. Hoyt, member of the committee; Dr. William Pace, one of the sponsors; Dr. Robert Hopkins and Dr. Edwin Artman.



Here members of the committee are shown again, this time presenting the Gold Award in the field of medical investigation to sponsors of the exhibit on "Surgery of Acquired and Congenital Heart Disease."



As many as six scientific sessions were going on at one time during certain periods in the Veterans Memorial Building. This group picture was taken in the Assembly Hall during one of the sessions.

bration were every fifth class beginning with that of 1909 and including that of 1954.

On Saturday morning the program on the campus featured primarily matters pertaining to medical and health education. A series of talks was given on the theme "Challenges in Health Education," and a panel discussion was presented on the subject "OSU College of Medicine—the Next 25 Years."

A banquet Friday evening and luncheon Satur-

day were highlights of the celebration as well as individual Class Reunion functions.

Chest Physicians Elect

The Ohio Chapter of the American College of Chest Physicians met as part of the Annual Meeting and reported an attendance of about 60 members and a successful program. The group elected officers as follows: Dr. George Kress, Columbus, president; Dr. Giles Wolverton, Dayton, vice-president; and Dr. F. G. Kravec, Youngstown, secretary-treasurer.

Panel Group and Scene in Exhibit Hall

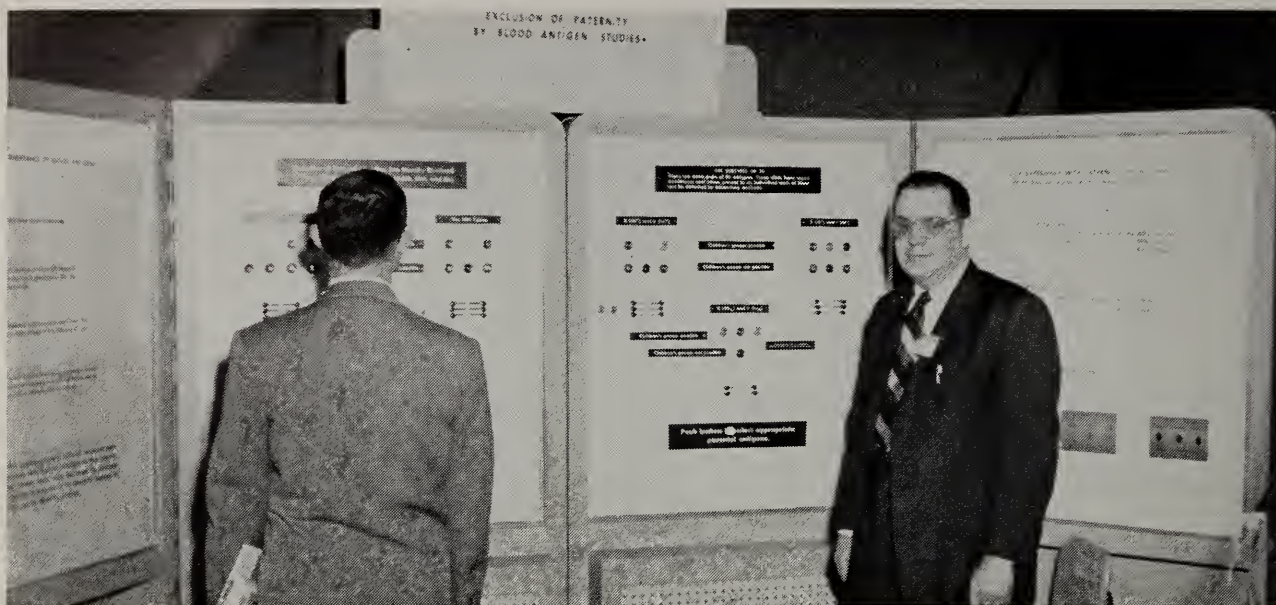


This group is typical of a number of panels which led programs during the Annual Meeting — this one on the subject "Hypertension." Left to right are Dr. Harry Goldblatt, Dr. Arthur Grollman, Dr. Maurice Schnitker, Dr. Harriet Dustan and Dr. Mitchell Perry.



The Scientific Exhibits furnished a popular place throughout the Annual Meeting as shown by this group picture.

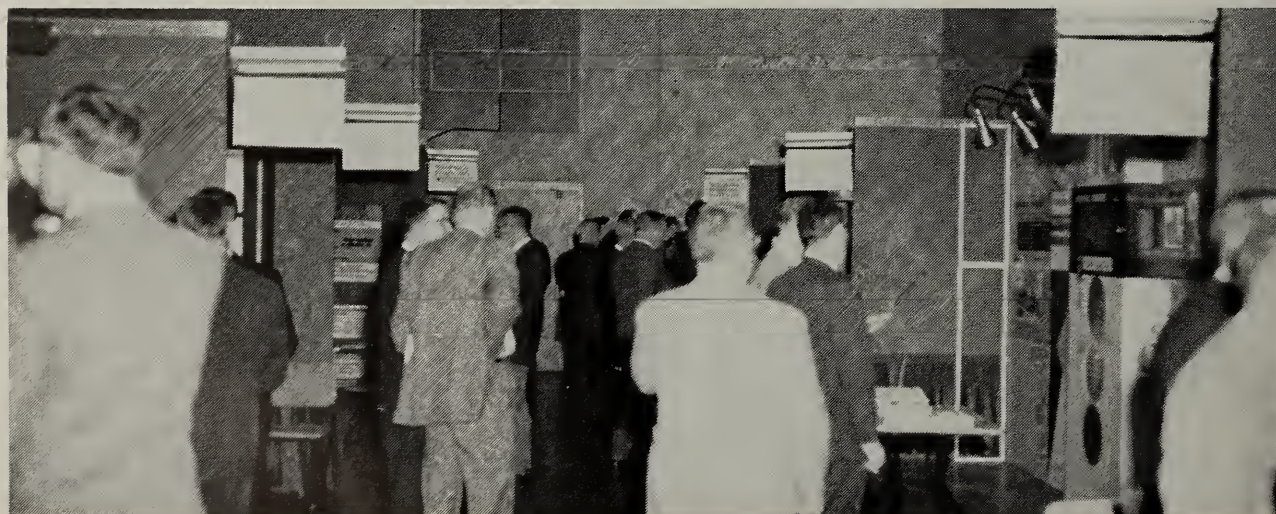
Some More of the Outstanding Scientific Exhibits



The Silver Award in the field of original investigation went to this exhibit on "Exclusion of Paternity by Blood Antigen Studies."



A Certificate of Merit went to this exhibit on "Maternal Health," which depicted extensive studies on this subject in Franklin County and throughout the State over a long period of time.



This is another view showing how members and visitors mingled between sessions in the Scientific Exhibit area.

House of Delegates

Dr. Mayfield Installed as President; Dr. Artman Selected As President-Elect; Several New Councilors and Delegates to the AMA Are Named

MINUTES OF FIRST SESSION

THE first session of the House of Delegates of the 1959 Annual Meeting of the Ohio State Medical Association was held in the Main Ballroom of the Neil House, Columbus, on Monday evening, April 20. There was a dinner with a business session following.

The session was called to order by Dr. James L. Henry, President of the Columbus Academy of Medicine. Dr. Henry introduced the Reverend William Gay, Pastor, Congregational Christian Church, Pleasant Hill, who offered the invocation.

Following the invocation, Dr. Henry officially welcomed the delegates to Columbus and then introduced the President, Dr. George A. Woodhouse, Pleasant Hill. Dr. Woodhouse then delivered his presidential address. (See pages 824-828 in this issue for Dr. Woodhouse's address.)

Delegates Present Numbered 140

Dr. T. L. Light, Dayton, chairman of the Credentials Committee, reported to the President that a total of 140 delegates, officers and councilors had been seated and were entitled to take part in the business proceedings.

The minutes of the 1958 sessions of the House of Delegates were approved, as published in *The Ohio State Medical Journal*, on motion duly made, seconded and carried.

At the request of Dr. Woodhouse, the delegates stood for a moment of silence in honor of the following past presidents whose deaths occurred during the past year: Dr. Clyde L. Cummer, Cleveland (1933-1934); Dr. John A. Caldwell, Cincinnati (1934-1935); and Dr. R. L. Rutledge, Alliance (1947-1948).

Introduction of Guests

The following guests were presented by Dr. Woodhouse and were given an ovation by the House of Delegates: Dr. Kenneth L. Olson, South Bend, Indiana, President, and Mr. James A. Waggener, Indianapolis, Indiana, Executive Secretary, Indiana State Medical Association; Mr. Stanton L. Freidberg, Cleveland, President of the Student Council, Western Reserve University School of Medicine; Mr. Jon P. Tipton, Columbus, President, Ohio State University Chapter,

Student American Medical Association; Mr. R. Robert Wilson, Columbus, Executive Secretary of the Ohio Academy of General Practice.

Also, Dr. Woodhouse introduced to the House of Delegates the new Editor of *The Journal*, Dr. Perry R. Ayres, Columbus, who was greeted with applause.

Auxiliary President Speaks

The House of Delegates was then addressed by Mrs. C. H. Bell, Mansfield, President of the Woman's Auxiliary to the Ohio State Medical Association. The text of Mrs. Bell's remarks will be found on Pages 867-870.

Reference Committees

President Woodhouse then appointed the following Reference Committees:

Credentials of Delegates—T. L. Light, Dayton, chairman; Carl A. Minning, Batavia; Paul A. Mielcarek, Cleveland; H. D. Chamberlain, McArthur.

President's Address—Isador Miller, Urbana, chairman; C. A. Colombi, Cleveland; Carl F. Goll, Steubenville; E. J. Meckstroth, Sandusky; Judson D. Wilson, Columbus.

Resolutions Committee No. 1—John H. Budd, Cleveland, chairman; Edmond K. Yantes, Wilmington; Kenneth D. Arn, Dayton; L. H. Goodman, Findlay; Thomas F. Tabler, Holgate; John R. Seesholtz, Canton; B. C. Diefenbach, Martins Ferry; J. L. Kraker, Lancaster; Keith R. Brandeberry, Gallipolis; Robert E. Swank, Chillicothe; James T. Stephens, Oberlin.

Resolutions Committee No. 2—Frank F. A. Rawling, Toledo, chairman; Charles A. Sebastian, Cincinnati; Maurice M. Kane, Greenville; Edwin W. Burnes, Van Wert; Benjamin S. Park, Painesville; G. E. DeCicco, Youngstown; Joseph W. Hamilton, Dover; Warren N. Koontz, Newark; A. R. Hambrick, Wellston; Philip B. Hardyman, Columbus; N. P. Stauffer, Millersburg.

Tellers and Judges of Election—F. P. Osgood, Toledo, chairman; Neil Millikin, Hamilton; John W. Gallagher, Piqua; Walter A. Hoyt, Jr., Akron; M. D. Shilling, Ashland.

Following the appointments, the chairmen of the various committees announced where their

committees would meet for the transaction of business.

Nominating Committee Chosen

The House of Delegates then nominated and elected the following Committee on Nominations:

First District—Daniel V. Jones, Cincinnati, who was named acting chairman.

Second District—George J. Schroer, Sidney.

Third District—Hobart L. Mikesell, West Liberty.

Fourth District—Frederick P. Osgood, Toledo.

Fifth District—Harry A. Haller, Cleveland.

Sixth District—G. E. DeCicco, Youngstown.

Seventh District—Carl F. Goll, Steubenville.

Eighth District—James A. L. Toland, Cambridge.

Ninth District—Harry Nenni, Ironton.

Tenth District—Charles W. Pavey, Columbus.

Eleventh District—George R. Wiseman, Amherst.

Introduction of Resolutions

The next order of business was the introduction of resolutions.

By official action, the House of Delegates ruled that resolutions which had been presented to the Columbus Office sixty days prior to the Annual Meeting and had been distributed in advance to members of the House of Delegates need not be read in their entirety but could be presented by a delegate by reading the resolution by title only.

Sixteen resolutions were presented by individual delegates by title only and were referred without debate to the Reference Committees on Resolutions. (See minutes of Second Session of the House of Delegates for the resolutions and actions thereon.)

By a two-thirds consent of the House of Delegates, a resolution relating to contagious diseases was presented by Dr. James D. Phinney, Hamilton County, and a resolution on insurance coverage for the aged was presented by Dr. Edmond K. Yantes, Clinton County. These resolutions also were referred to the Resolutions Committees. (See minutes of Second Session of the House of Delegates for resolutions and actions thereon.)

Charters Re-Issued

By official action, the House of Delegates approved re-issuance of copies of their charters to the following County Medical Societies: Licking, Madison and Muskingum.

Report on Proposed Poison Control Center

On behalf of The Council, the Executive Secretary presented a progress report from the Committee on Poison Control. The report, reading as

follows, was officially accepted by the House of Delegates:

At the 1958 Annual Meeting of the Ohio State Medical Association, the House of Delegates adopted the following resolution:

"WHEREAS, The many thousands of brand name chemical products available for farm, home and industrial use result in many accidental poisonings, a considerable number of which are fatal, and

"WHEREAS, Many of the larger metropolitan areas have established and successfully demonstrated the value of Poison Control Centers in reducing the toll from accidental poisonings; and

"WHEREAS, The high cost of establishing and maintaining adequate poison control centers prohibits this activity in any but the large metropolitan areas,

"THEREFORE BE IT RESOLVED, That the Council of the Ohio State Medical Association appoint a Poison Control Committee whose functions shall include:

"(1) The formulation of plans for the establishment of a single Central Poison Control Center for Ohio which shall provide authorized persons and institutions in all of Ohio's 88 counties with information, not available locally, on poison and poisonings, such information to be made available by telephone on a 24-hour-a day basis.

"(2) The initiation of a state-wide educational program on prevention of accidental poisoning.

"(3) A study of the need for additional legislation in Ohio for accurate and uniform labeling of products as to content, etc.

"(4) The securing of cooperation of hospital and pharmaceutical associations, drug manufacturers, safety councils, health departments and other interested groups in order to develop support for a comprehensive, state-wide poison control program."

Soon after the Annual Meeting, a Committee on Poison Control was named by President Woodhouse. The committee has made considerable progress with regard to items (2), (3) and (4) of the resolutions.

The committee believes that it is not possible at this time to develop a sound, practical plan for carrying out recommendation (1), namely, "that a single central poison control center for the entire state should be established."

At the December, 1958, meeting of The Council, the Committee on Poison Control presented the following report, which was accepted and approved by The Council:

"Following a motion by Dr. Jones, seconded by Dr. Wallace, the committee voted to adopt the following recommendation to The Council, for reference to the House of Delegates of the Ohio State Medical Association, in regard to Substitute Resolution No. 13:

"The committee has studied various methods of effectuating Section (1) of the resolution and suggests to The Council and to the House of Delegates of the Ohio State Medical Association that it does not consider feasible the establishment of a single central poison information center in Ohio at this time.

"The committee has investigated a number of suggestions for the establishment of such a center, including:

A. Administration by the OSMA.

B. Administration by the OSMA and other voluntary associations.

C. Administration by a state agency.

D. The extension of one of the existing centers.

"It was determined that financing and facilities were not available to establish an acceptable central center.

"In lieu of a single master center, therefore, the committee wishes to suggest that existing centers be strengthened, encouraged and utilized and made more readily accessible to physicians in rural areas. It is

further suggested that existing centers might, for the time being, obtain poison information from the National Clearing House in Washington, D. C., when necessary."

The Council believes that the views and alternative suggestions of the committee are sound and recommends that The Council's action in approving the committee's report be confirmed by this House of Delegates.

For the information of the House of Delegates, The Council would like to commend the committee and to point out that special articles on this subject are being published in *The Ohio State Medical Journal*; that the various approved local poison control centers in operation in Ohio are being listed in each issue of *The Journal*; that many conferences have been held with organizations and agencies for the purpose of discussing the feasibility of legislation for a more adequate poison control law in Ohio and the provisions of such a proposal. The committee expects to continue these—and additional activities—during the ensuing year.

Report on Retirement Income Program and Welfare Fund

On behalf of The Council, the Executive Secretary presented a progress report from the Committee on Auditing and Appropriations regarding a proposed retirement income program and welfare fund for members of the Association. By official action, the House of Delegates accepted this report, reading as follows:

At the 1958 Annual Meeting, the House of Delegates referred the following resolution to The Council and requested The Council to make a study of the subject of the resolution and report to the House of Delegates in 1959.

"WHEREAS, There is no established state-wide physicians welfare fund, and

"WHEREAS, There is no established state-wide low cost program offering retirement income to physicians, and

"WHEREAS, There is a definite need for the establishment of such a program in order to provide senior physicians and their families with security sufficient to preclude the reduction of their standard of living, beyond reason.

"THEREFORE BE IT RESOLVED. That the Ohio State Medical Association appoint or charge an already appointed committee to formulate a workable plan providing for a physician welfare fund and a retirement income program for members of the Ohio State Medical Association. This plan should emphasize a state-wide physician participation at a low cost basis. All avenues of conservative investment should be explored including group life insurance, variable annuities, and mutual fund shares. A voluntary plan should be set up, compulsory to a degree, in order to enforce savings for the development of a welfare fund and a retirement income program. It would operate under the auspices of the Ohio State Medical Association. Also, that the committee investigate the feasibility of the Ohio State Medical Association underwriting, as an agent, such a program. That consideration be given to the possibility of incorporating the cost of the program into the regular state membership dues. That the state membership dues be appropriately increased to cover the cost of this savings plan, and if necessary, dues to the Ohio State Medical Association be paid on a monthly basis in order to reduce the financial strain of such a program. That a study of the tax status of organizational dues paid to the Ohio State Medical Association be made including that part of the assessment placed in the welfare and retirement income fund."

This is a progress report from The Council, based on certain recommendations of the Committee on Auditing and Appropriations to which the resolution was assigned for study.

The matter is being studied by the committee in two parts, namely (1) the need for and feasibility of establishing a welfare fund, under the sponsorship of the Ohio State Medical Association, for aged members of the Association and members of their family who may need financial assistance in order to maintain reasonable living standards, and (2) the desirability and feasibility of a retirement income plan under the sponsorship of the Association for all members of the Association.

The committee is not ready at this time to make definite recommendations. It has taken the following steps to secure necessary information which will have to be evaluated carefully before specific recommendations can be presented to the House of Delegates:

1. Information is being obtained regarding welfare programs to aid physicians which may be carried on by medical societies in other states.

2. Efforts are being made to secure authentic information on procedures to be followed by physicians, individually or in groups, in qualifying under the Keogh-type proposals when and if such legislation is approved by Congress.

3. Investigation is being made of whether or not it would be desirable and feasible for the Ohio State Medical Association to set up a mechanism for group participation by its members under the provisions of a Keogh-type law.

4. Inquiry is being made of representatives of the insurance industry as to plans which they may have in mind to implement the proposed Keogh law; as to costs, advantages of group participation, etc. Similar inquiry is being made as to the operation of retirement income trust funds, not based on insurance contracts.

5. Legal counsel of the Association is working with the committee in its deliberations.

As stated at the beginning this is a progress report. When The Council has something definite to suggest it will present its recommendations to the House of Delegates for consideration and action.

There being no further business, the House of Delegates adjourned to meet on Thursday morning, April 23.

MINUTES OF SECOND SESSION

The second session of the House of Delegates of the Ohio State Medical Association at the 1959 Annual Meeting was held on Thursday morning, April 23, in the Main Ballroom, Neil House, Columbus, following a breakfast.

The first order of business was a report of the Credentials Committee. Dr. T. L. Light, Dayton, chairman of that committee, reported 153 delegates, officers and councilors seated and eligible to participate in the business proceedings.

Guests Introduced

President Woodhouse presented the following official guests who were given an ovation by the House of Delegates: Dr. G. B. Saltonstall, Charlevoix, Michigan, President of the Michigan State Medical Society; Dr. Allen W. Cowley, Harrisburg, Pennsylvania, President-Elect of the Medical Society of the State of Pennsylvania; Dr.

George F. Evans, Clarksburg, West Virginia, President of the West Virginia State Medical Association.

Committee on President's Address

Following the introduction of guests, the President called for the report of the Reference Committee on President's Address. This report was presented by Dr. Isadore Miller, Champaign County, chairman of the committee, and read as follows:

"The Committee on President's Address congratulates Dr. Woodhouse for his well presented address, and for his challenge to this House of Delegates and the County Medical Societies represented here to actively support the many programs and activities of the Ohio State Medical Association.

"On behalf of the members of the House of Delegates and the Ohio State Medical Association, we thank Dr. Woodhouse for his zeal and energetic leadership of this Association.

"Dr. Woodhouse's summary of the work of the many committees of this Association is indicative of the sincere interest and willingness of the Officers of this Association and the members of all these committees to serve unselfishly in meeting the needs of the people of Ohio in the areas of poison control, traffic safety, and care of the aged. Other committees representing this Association have been busy throughout the year in the fields of industrial medicine, workmen's compensation, maternal health, rural health, school health, public relations, hospital relations, mental health, and scientific works. One sees at once that a physician does more than just practice medicine.

"Dr. Woodhouse's report on the socio-economic problems involved in the care of the aged requires our most serious attention and concentrated efforts to find the most satisfactory solution to this growing problem. There are groups outside of the medical profession who say they have the answers to this problem. But Dr. Woodhouse points out that we must find the answer within the framework of the private practice of medicine. We repeat Dr. Woodhouse's plea for the earnest cooperation of all the members of the Ohio State Medical Association in working out an effective and acceptable plan for the care of the aged.

"Dr. Woodhouse is worried because the almost endless activities of the Association required many meetings on many Sundays. After a careful perusal of the Scriptures we wish to assure the President and the other officers of the Ohio State Medical Association that if they encounter any difficulties at the Pearly Gates it will be for other reasons.

"The Committee on President's Address expresses its appreciation for the privilege of making this report."

By official action, the report of the committee was approved. Members of the committee, in addition to Dr. Miller, were: Dr. C. A. Colombi, Cleveland; Dr. Carl F. Goll, Steubenville; Dr. Judson D. Wilson, Columbus; Dr. E. J. Meckstroth, Sandusky.

Action on Resolutions

The House of Delegates then took action on the following resolutions which had been referred to Resolutions Committee No. 1, chair-

manned by Dr. John H. Budd, Cleveland. Dr. Budd pointed out in his report that many members had appeared before the committee providing facts and opinions and this was very helpful to the committee in arriving at its decisions. He stated his committee wished to express appreciation to those who took the time to come before the committee during the hearings.

Increase in Dues

This resolution was introduced by Dr. Frank H. Mayfield, Cincinnati, on behalf of The Council. It read as follows:

BE IT RESOLVED, That the per capita annual dues of the Ohio State Medical Association be increased \$5.00, effective January 1, 1960, making the total amount of annual dues, \$30.

Dr. Budd reported the Committee endorsed this resolution.

On motion by Dr. Budd, seconded and carried, the recommendation of the committee, that the resolution on increase in dues be adopted, was approved.

Revisions in Medical Practice Act

This resolution was introduced by Dr. Kenneth D. Arn, Dayton and it read as follows:

WHEREAS, The Statutes of Ohio regulating the "Practice of Medicine and Surgery, Osteopathic Medicine and Surgery and Limited Branches" in many of its sections employ anachronistic terms such as "capper" and "drummer" (Sec. 4731.22 "A"); and

WHEREAS, Certain provisions of the Statutes are written in a manner that seriously limits or prohibits possibility of enforcement and accurate interpretation such as Section 4731.22 defining "Grossly unprofessional and dishonest conduct" and Section 4731.34 setting forth regulations that "shall be complied with" but provides no penalty for non-compliance;

THEREFORE BE IT RESOLVED, That the Council of the Ohio State Medical Association authorize a thorough study of said statutes by a committee appointed for that purpose and that the committee be requested to make recommendations to revise the statutes in order to modernize and strengthen them so that abuses thereof may be adequately controlled.

Dr. Budd reported that the committee was in agreement with the intent of this resolution and that after a discussion had formulated a substitute resolution reading as follows and recommended that it be adopted:

Sub. Res. on Revisions in Medical Practice Act

WHEREAS, It has been suggested that improvements be brought about in the present Ohio Medical Practice Act,

THEREFORE BE IT RESOLVED, That The Council of the Ohio State Medical Association authorize a thorough study of said statutes by an appropriate committee.

On motion by Dr. Budd, seconded and car-

ried, the committee's recommendation approving the substitute resolution was adopted.

Contagious Diseases

This resolution, introduced by Dr. James D. Phinney, Cincinnati, concerned the public health laws within the State pertaining to contagious diseases, and it read as follows:

WHEREAS, There has been of recent years considerable change in medical thinking and experience with regard to the so-called contagious diseases, and

WHEREAS, The various public health laws, rules and regulations currently of record within the State of Ohio are in a considerable number of instances not in line with such modern medical philosophy and practice,

THEREFORE BE IT RESOLVED, That the Ohio State Medical Association sponsor through an appropriate committee the formation of a review of these matters by competent representatives from those fields of endeavor intimately concerned, i. e., Public Health, Pediatrics, General Practice, Microbiology, Sanitation, etc., with the purpose of recommending suitable modernization of Public Health Laws, Rules and Regulations within the State of Ohio.

The report of the committee, Dr. Budd stated, favors the purpose of this resolution which, with several amendments, was reported back with a recommendation that it be approved. The amended resolution read as follows:

Am. Res. on Contagious Diseases

WHEREAS, There has been of recent years considerable change in medical thinking and experience with regard to the so-called contagious diseases, and

WHEREAS, The various public health laws and rules and regulations currently of record within the State of Ohio are in a considerable number of instances not in line with modern medical philosophy and practice,

THEREFORE BE IT RESOLVED, That the Ohio State Medical Association review these matters through an appropriate committee in cooperation with competent representatives from those fields of endeavor intimately concerned, for the purpose of recommending suitable modernization of public health laws and rules and regulations of Ohio pertaining to contagious diseases.

On motion by Dr. Budd, seconded and carried, the committee's recommendation, that the amended resolution be approved, was adopted.

American Medical Research Foundation

Dr. Kenneth D. Arn, Dayton, presented this resolution, which read as follows:

WHEREAS, There is widespread misunderstanding of the policy of the American Medical Association regarding the acceptance of funds for the American Medical Research Foundation, and

WHEREAS, There are groups and agencies ready and willing to give funds for health research to the American Medical Research Foundation.

THEREFORE BE IT RESOLVED, That the Ohio State Medical Association Delegates to the American Medical Association present a resolution to the House of Delegates of the American Medical Association, at its next meeting, calling for acceptance of funds by the American Medical Research Foundation offered by any legitimate source.

Dr. Budd reported that the committee, after a thorough discussion, voted to recommend the adoption of this resolution.

On motion by Dr. Budd, seconded and carried, the recommendation of the committee was adopted.

Ohio State Medical Research Foundation

A resolution on this subject was introduced by Dr. R. E. Tschantz, Canton. It read as follows:

1. WHEREAS, There is an increasing need for basic medical research into all diseases

2. WHEREAS, It is increasingly important that money for such research come from non-government sources

3. WHEREAS, More and more communities in Ohio are raising funds for medical research through Unified Health Drives, United Funds and similar charitable organizations

4. WHEREAS, Leadership by physicians is urgently needed in this field

THEREFORE BE IT RESOLVED, That the Ohio State Medical Association

1) Establish an Ohio State Medical Research Foundation into all diseases

2) That such a research foundation be administered predominately by physicians

3) That this Ohio State Medical Research Foundation be raised by contributions from United Health Drives, United Funds or similar charitable organizations and physicians throughout Ohio.

On behalf of the committee, Dr. Budd presented the following report on this resolution:

"After considering testimony the committee is of the opinion that this resolution should not be approved for the following reasons:

"(a) It would involve heavy administrative expenses and

"(b) It would be a duplication of similar efforts now being carried on by the American Medical Research Foundation."

On motion by Dr. Budd, seconded and carried, the recommendation of the committee, that this resolution not be adopted, was approved.

Multiple Health Fund Drives

Dr. Merritt K. Marshall, Marion, presented a resolution on this subject. It read as follows:

WHEREAS, It is felt that the number of medical research fund drives held annually is excessive and burdensome on the general public, and

WHEREAS, It is felt that the United Appeals Drive has shown that multiple drives for similar appeals can efficiently be held as a single drive, and

WHEREAS, It is felt that the multiplicity of organizations for National Health Research problems can well be grouped in one unit, it is

THEREFORE RESOLVED, That the Ohio State Medical Association go on record as recommending to the American Medical Association that the AMA take the leadership in attempting to organize all National Health Agencies under one unit, and it is also

RESOLVED, That the AMA sponsor one National Health Research Drive and then apportion the funds to the various medical agencies on a basis dependent on

their relative merits as to their importance from a medical standpoint.

The report of the committee presented by Dr. Budd pertaining to this resolution read as follows:

"After considering the views and information presented concerning this resolution the committee was of the opinion that this resolution should not be approved. The reasons for such action were as follows:

"Our own Association took action two years ago favoring in principle the formation of a federation embracing all voluntary health agencies, and the raising of such funds for a federation through a single drive, but advocated this be accomplished on a community basis. It is felt that it would not be wise or feasible to try to organize such programs on a state-wide or nation-wide basis. Moreover, the American Medical Association debated this question at the December 1958 meeting of the House of Delegates in Minneapolis and arrived at the same conclusions."

On motion by Dr. Budd, seconded and carried, the recommendation of the committee, that this resolution not be approved, was adopted by the House of Delegates.

Free Choice of Physician

This resolution was introduced by Dr. B. C. Diefenbach, Martins Ferry. It read as follows:

WHEREAS, The Ohio State Medical Association has always stood for reasonable degree of free choice of physician, and

WHEREAS, Section 22 of the Ohio Industrial Commission Code precludes such reasonable free choice of physician to injured employees of self-insured employers,

THEREFORE BE IT RESOLVED, That the Ohio State Medical Association go on record as opposing Section 22 of the Ohio State Industrial Commission and letting this opposition be known to the necessary authorities and that all reasonable action be taken to secure revocation of said Section 22 of the Ohio State Industrial Commission Code.

Dr. Budd reported that the committee favors the intent of this resolution and with certain amendments reports it back for approval and recommends its adoption. The amended resolution read as follows:

Am. Res. on Free Choice of Physician

WHEREAS, The Ohio State Medical Association has always stood for reasonable degree of free choice of physician, and

WHEREAS, The Ohio Workmen's Compensation Law precludes such reasonable free choice of physician by injured employees of self-insuring employers,

THEREFORE BE IT RESOLVED, That the Ohio State Medical Association go on record as favoring legislation which will bring about a reasonable degree of free choice of physician for injured employees of self-insuring employers and take steps to initiate such legislation if necessary.

On motion by Dr. Budd, seconded and carried, the committee's recommendation, that the amended resolution be adopted, was approved by the House of Delegates.

Medical Insurance for Aged

A resolution on this subject was introduced by Dr. Edmond K. Yantes, Wilmington. It read as follows:

WHEREAS, The House of Delegates of the American Medical Association requested that the doctors of the United States provide medical care for patients over 65 at fees they can afford to pay, and

WHEREAS, There are legislative proposals before Congress which would considerably restrict the care of the aged, and

WHEREAS, The Ohio Medical Indemnity is preparing a new contract to fit the income of this group, and

WHEREAS, Only full participation by the doctors of Ohio can make this plan successful,

THEREFORE BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association authorize a poll of the doctors of Ohio to ascertain their willingness to accept the new Ohio Medical fee schedule for patients over 65 on a service basis.

The report of the committee on this resolution was as follows:

"The committee strongly believes that the Association should initiate a program which will provide aged citizens with an opportunity to insure themselves against medical costs. During the discussion it was evident to the committee that there is a division of opinion among members of the medical profession as to the type of program which should be developed. For that reason, the committee is presenting for approval a substitute resolution which the committee believes will be acceptable to the medical profession of Ohio generally. The substitute resolution which the committee recommends be adopted reads as follows:"

Sub. Res. on Medical Insurance for Aged

WHEREAS, A need exists for a means to provide medical care for persons 65 or over at fees they can afford to pay,

THEREFORE BE IT RESOLVED, That the Ohio State Medical Association through an appropriate committee develop an insurance program providing benefits in reduced amounts and consequently at lower costs which would be within the means of these people, and

BE IT FURTHER RESOLVED, That the doctors of Ohio be urged to use this schedule as the basis of their fees where the financial circumstances of these patients indicate.

On motion by Dr. Budd, seconded and carried, the committee's recommendation, approving the substitute resolution, was adopted.

Social Security for Physicians

This resolution was presented by Dr. Eduard Eichner, Cleveland. It read as follows:

WHEREAS, Physicians are the only group at present not included in the Federal Old Age and Survivors In-

surance Program, commonly called "Social Security," and

WHEREAS, Non-inclusion of physicians in "Social Security" has been due in large part to official opposition to their inclusion on the part of the American Medical Association and its component Associations and Societies, and

WHEREAS, The October, 1958 poll of the members of the Ohio State Medical Association on the question of participation in "Social Security" indicated that of the members interested enough to have an opinion and vote, 59.9 per cent were in favor of inclusion of physicians in the "Social Security" program,

THEREFORE BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association record itself as approving in principle the participation of physicians in the Federal Old Age and Survivors Insurance Program, commonly called "Social Security," and

BE IT FURTHER RESOLVED, That this action in approving participation in the Federal Old Age and Survivors Insurance Program be reported to the House of Delegates of the American Medical Association at its June, 1959 meeting.

Dr. Budd reported that the committee had adopted a motion that this resolution not be adopted.

Dr. Budd moved that the recommendation of the committee, that this resolution not be adopted, be approved.

After the motion had been seconded, it was discussed by numerous delegates.

On a roll call vote, the motion by Dr. Budd, that the recommendation of the committee, namely, that this resolution not be adopted, was approved by a vote of 93 to 49. In taking such action, the House of Delegates did not approve inclusion of physicians in Social Security.

Dr. Budd then moved that the report of the committee as a whole be adopted. The motion was duly seconded and adopted.

Appreciation to Committee

At the conclusion of his report, Dr. Budd stated that he would like to assure the House that the recommendations of the committee came about after diligent and sincere consideration of the testimony presented and the issues involved. He said the committee was grateful for the attendance and participation of so many who came to the meeting and that he wished to record his personal gratitude to the members of the committee for their patience, enthusiasm and wisdom. Members of the committee participating were: Edmond K. Yantes, Clinton County; Kenneth D. Arn, Montgomery County; Lawrence H. Goodman, Hancock County; Thomas F. Tabler, Henry County; John R. Seesholtz, Stark County; Benjamin C. Diefenbach, Belmont County; Jack L. Kraker, Fairfield County; Robert E. Swank, Ross County; James T. Stephens, Lorain County.

Dr. Woodhouse then called for the report of Resolutions Committee No. 2. This report was presented by Dr. Frank F. A. Rawling, Toledo, chairman of the committee.

AAPS Essay Contest

This resolution was introduced by Dr. Charles W. Pavey, Columbus, and read as follows:

WHEREAS, The House of Delegates of the OSMA has for several years approved the Essay Contest of the Association of American Physicians and Surgeons on the Advantages of Private Medical Care or The Advantages of The American System of Free Enterprise and

WHEREAS, Many auxiliaries of the OSMA throughout the state have conducted such Essay Contests and

WHEREAS, Continued acceptance of the contest by the auxiliaries is contingent upon approval by the House of Delegates and

WHEREAS, Participation in such contests tends to teach the essayists the facts on these subjects

THEREFORE BE IT RESOLVED, That the House of Delegates of the OSMA reaffirm its approval of said essay contest.

Dr. Rawling reported that his committee recommended approval of this resolution.

On motion by Dr. Rawling, seconded and carried, the recommendation of the committee was approved.

Protection in Athletics

Dr. Sol Maggied, West Jefferson, presented this resolution which read as follows:

WHEREAS, Professional Athletics, football especially, is causing a profound effect on Athletics (on coaches, on officials and on the athletes) especially at the High School level, and

WHEREAS, This effect is adding to the injury potential and causing an increasing number of unnecessary injuries, and

WHEREAS, This august body needs to continue its interest in protective and preventive measures,

BE IT HEREBY RESOLVED, That the Ohio State Medical Association use its offices to create a liaison between the Ohio State Medical Association and the Rules Committee of the Ohio State Athletic Association thus to be of medical assistance in the protective phase of rules interpretations.

Dr. Rawling reported that the committee had suggested certain amendments to the original resolution and that it reported back the amended resolution with a recommendation that the amended resolution be approved by the House of Delegates. Dr. Rawling moved that the amended resolution be approved. The motion was seconded.

Dr. Mayfield moved an amendment to the amended resolution, namely, that the second "Whereas," reading as follows, "Whereas, This effect is adding to the injury potential and resulting in an increasing number of preventable injuries," be eliminated. The motion to amend was seconded and adopted.

The House of Delegates then voted on Dr.

Rawling's motion and the amended resolution, as amended on the floor, was adopted. It read as follows:

Am. Res. on Protection In Athletics

WHEREAS, The examples set by professional athletics, football especially, are having a profound effect on the conduct of athletics at the high school level, and

WHEREAS, This should be a matter of concern to the medical profession, educators and the general public

WHEREAS, The level of physiological development at the high school age presents problems not usually found in mature players with respect to equipment, rules interpretations, etc., in the interest of the safety of the player

WHEREAS, The Committee on School Health of the Ohio State Medical Association has established close liaison with officials of the Ohio High School Athletic Association,

THEREFORE BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association, in official session April 23, instruct this committee to take up this problem promptly with the appropriate officials to the end of establishing all possible safeguards for the health and safety of the high school players.

Sixty Day Deadline For Resolutions

This resolution was introduced by Dr. Sol Maggied, West Jefferson. It read as follows:

WHEREAS, Tradition has always allowed the democratic method of introducing resolutions from the floor, annually only, and,

WHEREAS, Tradition has always allowed that controversial or indecisive resolutions be referred to Council for further action, and,

WHEREAS, This august body is one of the few remaining active bodies propounding active democracy,

BE IT HEREBY RESOLVED, That last year's resolution number two (2) (which changed the Constitution and By-Laws and caused a sixty (60) day deadline for resolutions) be revoked and that this section of the Constitution of the Ohio State Medical Association read as prior to the Ohio State Medical Association meeting of 1958 in essence, namely, that resolutions may be introduced from the floor of the House of Delegates.

Dr. Rawling's report on this resolution read as follows:

"The committee was enlightened by the discussion of proponents of the resolution. Apparently the intent of introducing this resolution was to call to our attention the conflict of the statement on page 6 of the Delegate's Handbook which permits the Resolutions Committee to draft and submit a substitute resolution, and Chapter 4, Section 8, of the By-Laws which state: 'No consideration may be given, or any action taken, by the Committee on Resolutions or the House of Delegates, with respect to any resolution unless such resolution shall have been presented or introduced at the opening session of the meeting of the House of Delegates.'

"To clarify this, the committee recommends to The Council that it take appropriate action to add the following sentence to the end of Section 8 of the By-Laws, as follows: 'This requirement shall not interfere with the right of

the Resolutions Committee to introduce composite or substitute resolutions.'

"For these reasons your committee recommends that the resolution not be adopted."

Dr. Rawling moved that the recommendation of the committee, that this resolution not be adopted, be approved. It was seconded and carried.

Indemnity Insurance

The resolution on this subject was introduced by Dr. Kenneth D. Arn, Dayton. It read as follows:

WHEREAS, The pre-payment voluntary insurance plans are assuming an increasingly important role in determining the future course of organized medicine; and

WHEREAS, We believe the indemnity principle in pre-payment health insurance programs offers the best promise of serving the needs of our people; and

WHEREAS, The Council of the Ohio State Medical Association through the Board of Directors of the Ohio Medical Indemnity has steadfastly supported the indemnity philosophy; and

WHEREAS, The medical service committee of the Ohio State Medical Association has effectively expounded the position of the Ohio State Medical Association in its negotiations with the Medicare authorities; and

WHEREAS, At the December 1958 meeting of the American Medical Association house of delegates the Ohio delegation by its efforts effected changes in the A. M. A. trustee sponsored old age program to bring it into agreement with the position of the Ohio State Medical Association;

THEREFORE BE IT RESOLVED, First, that this body commend the Council of the Ohio State Medical Association and the Board of Directors of the Ohio Medical Indemnity for the successful operation of the corporation;

Second, that this assembly take note of the dynamic leadership exercised by the committee on medical care and the activity of the Ohio delegates to the American Medical Association in the preservation of our principles;

Third, that this house of delegates re-affirm its endorsement of the indemnity approach in meeting our health insurance requirements.

Dr. Rawling reported that his committee recommends the adoption of the resolution.

On motion by Dr. Rawling, seconded and carried, the recommendation of the committee was adopted.

Compulsory Immunization

This resolution was introduced by Dr. G. E. DeCicco, Youngstown. It read as follows:

WHEREAS, It is agreed that immunization of children against diphtheria, whooping cough, tetanus, poliomyelitis and smallpox has greatly reduced the incidence of these diseases and

WHEREAS, By reducing the occurrence rate in those so immunized such immunization has correspondingly diminished the frequency in those not so immunized and

WHEREAS, Such immunization can be accomplished easily and safely in the preschool child, therefore

BE IT RESOLVED, That the Ohio State Medical Association go on record as approving compulsory immunization against diphtheria, tetanus, whooping cough,

One of Two Busy Sessions of the House of Delegates



It was a busy time for members of the House of Delegates who held their first session Monday evening and the second Thursday morning, with perhaps a number of committee meetings between. Here Delegates are shown in a busy session.

smallpox and poliomyelitis of all children prior to entrance to either public or private schools, and, further

BE IT RESOLVED. That the Ohio State Medical Association, through its appropriate committee, have introduced and passed into law by the Ohio State Legislature the necessary legislation to effectively implement this resolution.

Dr. Rawling reported that his committee felt that the intent of this resolution should be broadened and therefore presented the following amended resolution:

Am. Res. on Compulsory Immunization

WHEREAS. It is agreed that immunization against diphtheria, whooping cough, tetanus, poliomyelitis and smallpox has greatly reduced the incidence of these diseases and

WHEREAS. By reducing the occurrence rate in those so immunized such immunization has correspondingly diminished the frequency in those not so immunized and

WHEREAS. Such immunization can be accomplished easily and safely in the pre-school child and even more effectively in infancy,

THEREFORE BE IT RESOLVED. That the Ohio State Medical Association urge universal immunization against all communicable diseases for which there is an effective immunizing agent, such as diphtheria, whooping cough, tetanus, smallpox and poliomyelitis and support any program to implement this that is acceptable to this Association.

Dr. Rawling moved that the report of the committee recommending the adoption of the amended resolution be approved by the House of Delegates. The motion was seconded.

Dr. James D. Phinney, Cincinnati, moved the substitution of the following resolution for the amended resolution:

Sub. Res. on Universal Immunizations

WHEREAS. It is agreed that immunizations against diphtheria, whooping cough, tetanus, poliomyelitis and smallpox have greatly reduced the incidence of these diseases, not only among the immunized but also with

the exception of tetanus among the non-immunized as well, and

WHEREAS. Such immunization may generally be accomplished easily and safely among infants and pre-school children, therefore

BE IT RESOLVED. That the Ohio State Medical Association urge that as universally as possible infants and pre-school children be immunized against at least diphtheria, whooping cough, tetanus, poliomyelitis and smallpox, and further

BE IT RESOLVED. That the Ohio State Medical Association support such programs towards this end, that are acceptable to this Association.

Dr. Phinney's motion was seconded. Following a discussion, Dr. Phinney's motion was adopted by the House of Delegates and the substitute resolution therefore was approved.

Polio Immunization

This resolution was introduced by Dr. Fred R. Kelly, Cleveland. It read as follows:

WHEREAS. A safe effective poliomyelitis vaccine has now been developed, and

WHEREAS. A widespread community polio vaccine program sponsored by the Academy of Medicine of Cleveland and Cuyahoga County Medical Society has proved to be most effective in reducing the number of cases of poliomyelitis,

THEREFORE BE IT RESOLVED: I. That the Ohio State Medical Association urge the state legislature to establish laws requiring the immunization of all public school children against polio.

II. That this polio vaccine program be made a part of the health program of the public and parochial schools of Ohio.

Dr. Rawling stated "The committee recommends that this resolution be tabled since the intent of this resolution is carried out in the resolution regarding compulsory immunization that has been presented."

Dr. Rawling moved that the recommendation

of the committee on this resolution, namely, that it be tabled, be adopted. The motion was seconded and carried.

Regulation of Speed and Noise of Ambulances

A resolution on this subject was presented by Dr. F. P. Osgood, Toledo. It read as follows:

Traffic accidents are taking an appalling toll of our citizenry; there were 135 accidents with 8 deaths in Ohio in 1957 involving emergency vehicles.

As physicians we are avowed guardians of the general welfare of our fellow men and

WHEREAS, The excessive speed and noise exhibited by ambulances creates confusion on the city streets and jeopardizes the safety of lives,

WHEREAS, Medical experience has shown beyond argument that no useful purpose has been accomplished by noisy ambulances proceeding at excessive speeds,

WHEREAS, Medical experience has demonstrated that co-ordinated timing and team work rather than speed determines the outcome in emergency situations,

WHEREAS, Studies in metropolitan centers has shown that 98.0 per cent of cases were adequately handled within the 35 m.p.h. restriction,

WHEREAS, Ambulance driver personnel trained in the proper handling of accident victims are prepared to render emergency first aid to victims at the scene of an accident, thereby nullifying the need for excessive speed,

WHEREAS, Any measures that promote safety in vehicular traffic as outlined by the Ohio Department of Highway Safety should be given consideration;

THEREFORE BE IT RESOLVED, That the Ohio State Medical Association recommend to the Ohio State Legislature

1) That all ambulances, both private and police, be required by edict to obey all traffic laws, in conformity with other vehicular traffic as regards speed, right of way, traffic lights and signs and common courtesy;

2) That a program of education for proper training of all ambulance personnel in the emergency care of accident victims be initiated and maintained; and

3) That such properly trained personnel be licensed through qualified channels by examination, renewable at periodic intervals.

The report of the committee on this resolution stated that it was brought out during a hearing that legislative action should not be recommended by this body since the conditions under which emergency motor vehicles operate vary with the size of the community. Dr. Rawling said his committee felt that the resolution, as presented, was too specific in the restrictions it recommended be placed on the operation of ambulances.

Dr. Rawling reported that his committee desired to present a substitute resolution. The substitute resolution was presented by Dr. Rawling who moved that it be adopted. The motion was seconded. During the discussion, an amendment of the second "Whereas" to strike out the words "not always" and insert the word "rarely" was adopted. The substitute resolution,

as amended, was then approved by the House of Delegates. It read as follows:

Sub. Res. on Regulation of Speed and Noise of Ambulances

WHEREAS, There are numerous instances where speeding emergency vehicles endanger the public and the patient and

WHEREAS, From a medical viewpoint such speed is rarely necessary for the welfare of the patient,

THEREFORE BE IT RESOLVED, That each county medical society be urged to initiate and maintain an educational program in its community to include instruction in the proper handling and safe transportation of patients.

Bed Taxes on Physicians

This resolution was introduced by Dr. Eugene A. Ferreri, Cleveland. It read as follows:

WHEREAS, The practice of direct assessment by a hospital or its agent of a fee or tax (such as an admis-



Dr. Edwin H. Artman (facing camera) is congratulated by Dr. Woodhouse and presented to the House of Delegates upon his selection as President-Elect.

sion fee, operating room fee, per diem fee, etc.) on a physician for use of hospital facilities by the physician's patient is growing, and

WHEREAS, Such practices are developed to provide funds for capital improvement or administration of hospitals because other sources of revenue are diminishing, and

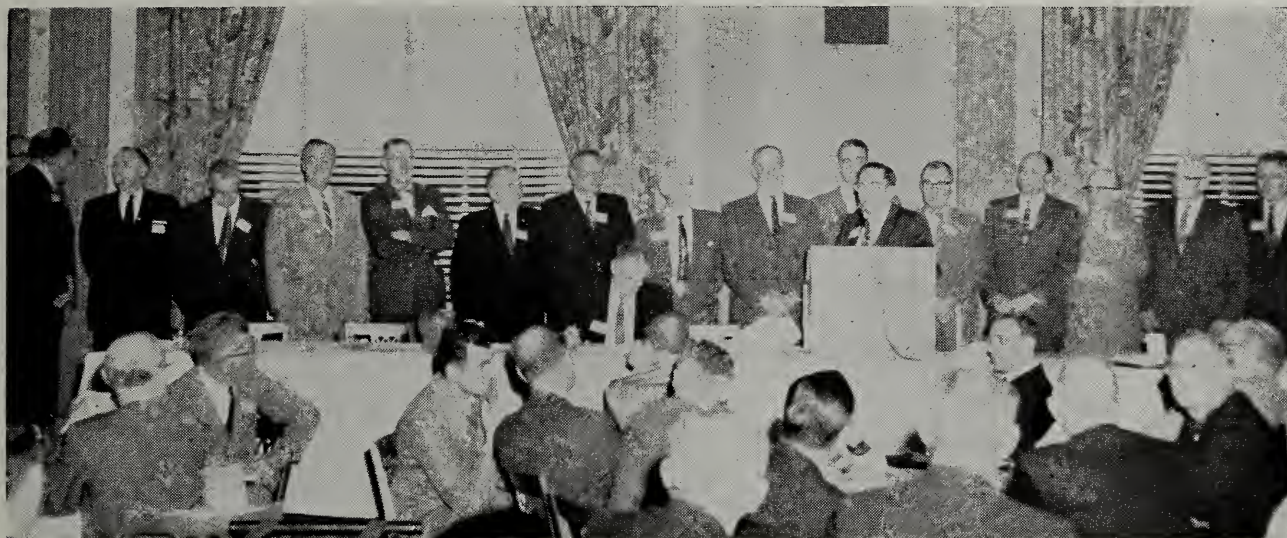
WHEREAS, Although physicians have increased responsibilities for hospitals compared to other citizens, their contribution to hospitals should nevertheless be made under conditions similar to those for all voluntary contributions—freely, independently, and in relation to financial means without fear of reprisal, and

WHEREAS, Physician acceptance and cooperation in direct assessment plans may involve coercion and implied threats of sanctions and loss of hospital privileges, and

WHEREAS, A basic tenet of philanthropy is free choice of assignee, and

WHEREAS, In most instances, the above mentioned fee or tax is a hidden additional fee for the patient,

Leaders in OSMA Work Stand for Recognition



Following the election at the final session of the House of Delegates, new and former members of The Council and AMA Delegates (some of whom are shown here) were presented by the President.

involving a third party, a practice defined as unethical by the American Medical Association code of ethics, and

WHEREAS, In most instances, physicians have no representation in the disposition and administration of money when collected by the above mentioned plans, and such collections therefore represent taxation without representation and

WHEREAS, The return to the hospital of part of the fee paid by the patient supposedly as reimbursement for service of the physician alone may well be a modified form of fee-splitting as defined by the Judicial Council of the American Medical Association,

THEREFORE BE IT RESOLVED, That the Ohio State Medical Association firmly opposes compulsory assessment of physicians with or without the majority approval of the medical staff of a hospital through such devices as an admission fee, operating room fee, per diem fee, bed tax fee, or other such fees. Contribution to the hospital by a hospital's medical staff for either day to day operation or construction of new facilities should be on a completely voluntary basis.

Dr. Rawling, on behalf of his committee, moved that this resolution be adopted. The motion was seconded and carried.

Licensing of Paramedical Groups

Dr. Philip J. Robecheck, Cleveland, presented a resolution on this subject and it read as follows:

WHEREAS, Numerous paramedical groups now exist that assist physicians in diagnosing and treating patients; and

WHEREAS, There appears to be an ever increasing desire on the part of these paramedical groups to enhance their stature through various means; and

WHEREAS, Senate Bill Number 11 (Ocacek-Renner) has been introduced into the Ohio State Legislature calling for the creation of a State Board of Psychologists for the certification and regulation of psychologists; and

WHEREAS, Organized medicine at every level is taking added interest in the affairs of these paramedical groups and is making a conscientious effort to bring prestige to these medical assistants; and

WHEREAS, The House of Delegates of the American Medical Association at the interim session in December,

1958, went on record as encouraging the voluntary registration of paramedical personnel; and

WHEREAS, The House of Delegates at the said December meeting also opposed the extension of governmental licensure and governmental registration;

THEREFORE BE IT RESOLVED, That the Ohio State Medical Association opposes governmental licensure or registration for any paramedical groups; and

BE IT FURTHER RESOLVED, That the Ohio State Medical Association vehemently reiterates its stand that such paramedical groups should function only under the adequate supervision of licensed physicians and surgeons.

The report of Dr. Rawling's committee on this resolution read as follows:

"The Ohio State Medical Association is already on record as being opposed to Senate Bill No. 11, calling for the creation of a State Board of Psychologists for the certification and regulation of psychologists.

"Furthermore, paramedical groups and their relationship to the medical profession are not clearly defined and are indeed complex. The situation is under continuing study by committees of the American Medical Association and our committee feels that we should reserve our decision until the national committees have arrived at a basic understanding and we have had time to consider the problem further. For these reasons, the committee felt it wisest that this resolution be tabled at the present time."

Dr. Rawling moved that the recommendation of the committee, that this resolution be tabled, be adopted by the House of Delegates. The motion was seconded and carried.

On motion by Dr. Rawling, seconded and carried, the report of the Resolutions Com-

mittee No. 2 as a whole, as amended, was approved by the House of Delegates.

Committee Thanked

Dr. Rawling informed the House of Delegates that the task of preparing the report was made much easier by the cooperation and suggestions of many people whom the committee would like to thank personally and on behalf of the House of Delegates. He said the work of the committee was difficult but important and he wished to thank all members of his committee for their fine cooperation and help. The members of Resolutions Committee No. 2 were as follows: Charles A. Sebastian, Hamilton County; Maurice M. Kane, Darke County; Edwin W. Burnes, Van Wert County; Benjamin S. Park, Lake County; G. E. DeCicco, Mahoning County; Joseph W. Hamilton, Tuscarawas County; Warren N. Koontz, Licking County; Philip B. Hardyman, Franklin County; and N. P. Stauffer, Holmes County.

Election of President-Elect

The next order of business was the nomination and election of a President-Elect. Dr. Woodhouse called for nominations.

Dr. Judson D. Wilson, Columbus, placed in nomination the name of Dr. Edwin H. Artman, Chillicothe. The nomination was seconded by Dr. T. L. Light, Dayton.

There being no further nominations, on motion by Dr. Orr and seconded, the nominations were closed and Dr. Artman was declared elected unanimously as President-Elect for the ensuing year.

Dr. Wilson, on the request of the President, escorted Dr. Artman to the rostrum, at which time Dr. Artman was given an ovation and he made a brief speech of acceptance.

Election of Councilors

The report of the Committee on Nominations was then presented by Dr. Daniel V. Jones, Cincinnati, Chairman of the committee.

The committee placed in nomination for members of The Council the following: **Second District**—Dr. Ray M. Turner, Springfield, to succeed Dr. R. Dean Dooley, formerly of Dayton who is now a resident of Columbus, having accepted a full-time position as director of the Department of Professional Relations of Ohio Medical Indemnity, Inc.;

Fourth District—Dr. W. W. Green, Toledo, succeeding Dr. Paul F. Orr, Perrysburg, who had served the constitutional limit of three consecutive terms on The Council and therefore was ineligible for re-election;

Sixth District—Dr. Robert E. Tschantz, Can-

ton, succeeding Dr. Carl A. Gustafson, Youngstown, who had served the constitutional limit of three consecutive terms on The Council and therefore was ineligible for re-election;

Eighth District—Dr. William D. Monger, Lancaster, to succeed himself;

Tenth District—Dr. Robert Inglis, Columbus, to succeed Dr. Edwin H. Artman, Chillicothe, who had completed the constitutional limit of three consecutive terms on The Council and was ineligible for re-election; and had just been elected President-Elect.

There being no nominations from the floor,



Outgoing President George A. Woodhouse (left) presents the gavel to Incoming President Frank H. Mayfield at the final session of the House of Delegates.

the nominations were closed and the secretary was instructed to cast the unanimous ballot of the House of Delegates for Doctors Turner, Green, Tschantz, Monger and Inglis. This was done and the President declared them elected for a term of two years, 1959-1960 and 1960-1961.

AMA Delegates and Alternates

Delegates and alternates to the American Medical Association to serve for a term of two years beginning January 1, 1960; were nominated by the Committee on Nominations as follows:

Dr. John H. Budd, Cleveland, delegate, and Dr. Edmond K. Yantes, Wilmington, alternate.

Dr. Carll S. Mundy, Toledo, delegate, and Dr. Paul F. Orr, Perrysburg, alternate.

Dr. Charles A. Sebastian, Cincinnati, delegate, and Dr. J. Robert Hudson, Cincinnati, alternate.

Dr. C. C. Sherburne, Columbus, delegate, and Dr. Philip Hardyman, Columbus, alternate.

Dr. Richard L. Meiling, Columbus, delegate,

A Get-Together of OSMA Past-Presidents



Nine Past-Presidents of the Association were present at The Council dinner given for Councilors, Past-Presidents, AMA Delegates and other distinguished guests. Seated left to right are Dr. Richard L. Meiling, Dr. George A. Woodhouse (then President), Dr. H. M. Platter and Dr. Harve M. Clodfelter. Standing, left to right, are Dr. Robert S. Martin, Dr. Fred W. Dixon, Dr. Carl A. Lincke, Dr. C. C. Sherburne and Dr. Paul A. Davis.

and Dr. Carl A. Gustafson, Youngstown, alternate.

There being no further nominations, on motion duly made, seconded and carried, the nominations were closed and the secretary was instructed to cast the unanimous ballot of the House of Delegates for the foregoing for the office of delegate and the office of alternate to the American Medical Association for two-year terms starting January 1, 1960.

The Nominating Committee also placed in nomination the names of Dr. Richard L. Meiling, Columbus, and Dr. Carl A. Gustafson, Youngstown, to serve as delegate and alternate to the AMA for the calendar year 1959, inasmuch as the Association is entitled to a ninth delegate in 1959.

There being no further nominations, on motion duly made, seconded and carried, the nominations were closed and the secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Meiling as delegate and Dr. Gustafson as alternate for the calendar year 1959.

The Nominating Committee placed in nomination the name of Dr. Philip Hardyman, Columbus, as alternate to Dr. C. C. Sherburne, Columbus, for the calendar year 1959, to succeed Dr. Richard L. Meiling, Columbus, who had been elected a delegate.

There being no further nominations, on motion duly made, seconded and carried, the nominations were closed and the secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Hardyman as alternate to Dr. Sherburne for the calendar year 1959.

The Nominating Committee placed in nomination the name of Dr. T. L. Light, Dayton, as alternate to Dr. George A. Woodhouse, Pleasant Hill, an AMA Delegate, to succeed Dr. R. Dean Dooley, Dayton, who had resigned as alternate and whose resignation had been accepted by The Council.

There being no further nominations, on motion duly made, seconded and carried, the nominations were closed and the secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Light as alternate to Dr. Woodhouse, to serve until December 31, 1960.

Inaugural Ceremony

After Dr. Jones had thanked the members of his committee for their cooperation and assistance, Dr. Woodhouse requested that all officers and delegates elected at this meeting come to the rostrum so they could be installed. Following the installation ceremony, Dr. Woodhouse presented

the official gavel of the Association to the incoming President, Dr. Frank H. Mayfield, Cincinnati.

Address of Incoming President

Dr. Mayfield accepted the gavel and in turn presented Dr. Woodhouse with the official gold past-president's button. Dr. Mayfield then addressed the House of Delegates. (See pages 863-866 for the inaugural address of Dr. Mayfield.)

As his first official act, Dr. Mayfield made the following standing committee appointments which were officially confirmed by the House of Delegates:

Committee on Education—Dr. Thomas S. Brownell, Akron, appointed for a term of five years. Dr. Thomas E. Rardin, Columbus, a member of the committee, reappointed chairman for the ensuing year.

Judicial and Professional Relations Committee—Dr. Frederick T. Merchant, Marion, for a term of five years. Dr. Daniel E. Earley, Cincinnati, a member of the committee, reappointed chairman for the ensuing year.

Committee on Public Relations and Economics—Dr. Frederick P. Osgood, Toledo, reappointed for a term of five years and reappointed as chairman for the ensuing year.

Committee on Scientific Work—Dr. John D. Battle, Cleveland, appointed for a term of five years. Dr. Benjamin Felson, Cincinnati, reappointed and for a term of five years. Dr. Maurice Schnitker, Toledo, a member of the committee, appointed chairman for the ensuing year.

Resolution of Thanks

After the appointment and confirmation of the committees, Dr. Sebastian, Cincinnati, presented a motion expressing appreciation on behalf of the Ohio State Medical Association to all who had any part in the annual meeting or preparing for it; to the physicians of Columbus and their wives for their courtesies; to the various state and local committees; to the press, radio, and TV, and managements of the hotels and Veterans Memorial for the part which they played in making this year's meeting so successful. **The motion was adopted unanimously by the House of Delegates.**

The House of Delegates was advised that the 1960 Annual Meeting would be held in Cleveland the week of May 15, with the Sheraton-Cleveland as the headquarters hotel, and the scientific sessions in the Cleveland Public Auditorium.

There being no further business, the House of Delegates adjourned sine die.

Attest: CHARLES S. NELSON,
Executive Secretary.

New Members of OSMA

The following are the names of the new members of the Ohio State Medical Association since April 1, 1959. The list shows the county in which they are affiliated, city in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

Ashtabula County
Reginald W. Shelby,
Ashtabula

Auglaize County
Robert S. Sobocinski,
Wapakoneta

Butler County
Salvador Alatorre, Hamilton
Michael N. Cardis,
Hamilton

Clermont County
Richard K. Lancaster,
Batavia

Cuyahoga County
Constance Curtiss,
Cleveland
William G. Kovats,
Cleveland
Felix C. Lewkowicz,
Cleveland
Carlos A. Maldonado,
North Olmsted
Nelson G. Richards,
Cleveland

Erie County
Howard C. Smith,
Sandusky

Fairfield County
Pauline Garber, Lancaster

Franklin County
David A. Ucker, Columbus

Guernsey County
Andrew Shawala, Cambridge

Hamilton County
August H. Lambers,
Cincinnati
Sidney Prystowsky,
Cincinnati
Donald I. Radin,
Cincinnati
Richard T. Wurzelbacher,
Cincinnati
Juan Young, Cincinnati

Lucas County
Joseph F. Boyd, Jr.,
Toledo
Henry R. Silverman, Jr.,
Toledo

Mahoning County
James H. Fulks, Youngstown

Montgomery County
Leonard W. Cobbs, Dayton
Louis J. Goetz, Dayton
Harold C. Stratton, Dayton

Scioto County
Francis E. Kulcsar,
Portsmouth

Trumbull County
Maurice Snell, Warren

Course in Occupational Skin Problems At University of Cincinnati

The Institute of Industrial Health of the University of Cincinnati announces that the fourth biennial course of instruction in *Occupational Skin Problems* will be given during the week of October 26-30, 1959. It will be presented by the Department of Preventive Medicine and Industrial Health, University of Cincinnati, in collaboration with the Occupational Health Program of the United States Public Health Service, and the Department of Dermatology of the University of Cincinnati. The objective of this course is to give physicians a greater understanding of cutaneous problems of occupational origin.

Physicians interested in attending the course or obtaining additional information should write for an application blank to Secretary, Institute of Industrial Health, The Kettering Laboratory, Eden and Bethesda Avenues, Cincinnati 19, Ohio. Early application is advised since attendance will be limited.

HOUSE OF DELEGATES ROLL CALL—1959 MEETING

County	Delegate	First Session	Second Session
FIRST DISTRICT			
ADAMS	John R. Donohoo	Present	Present
BROWN	John A. Carter	Present	Present
BUTLER	Neil Millikin	-----	Present
CLERMONT	Carl A. Minning	Present	Present
CLINTON	Edmond K. Yantes	Present	Present
HAMILTON	Robert A. Bader	-----	Present
	Charles D. Bahl	-----	Present
	Joseph G. Crotty	Present	Present
	Harry K. Hines	-----	Present
	Richard B. Homan	Present	Present
	J. Robert Hudson	Present	Present
	Donald L. Jacobs	Present	-----
	Daniel V. Jones	Present	Present
	William A. Moore	Present	Present
	James D. Phinney	Present	Present
	Clyde S. Roof	-----	Present
	Charles A. Sebastian	Present	Present
	Earl C. Van Horn	-----	Present
HIGHLAND	Clifford Foor	-----	Present
WARREN	Thomas E. Fox	-----	Present
SECOND DISTRICT			
CHAMPAIGN	Isador Miller	Present	Present
CLARK	J. H. Shanklin	Present	Present
	Ray M. Turner	Present	Present
DARKE	Maurice M. Kane	Present	Present
GREENE	Paul D. Espey	Present	Present
MIAMI	John W. Gallagher	Present	Present
MONTGOMERY	Kenneth D. Arn	Present	Present
	John Robert Brown	Present	Present
	Charles L. Kagay	Present	Present
	Theodore L. Light	Present	Present
	James G. Tye	Present	Present
	C. J. Brian	Present	Present
PREBLE	George J. Schroer	Present	Present
SHELBY			
THIRD DISTRICT			
ALLEN	Dwight L. Becker	Present	Present
	Fred P. Berlin	Present	Present
AUGLAIZE	Elizabeth Y. Kuffner	Present	Present
CRAWFORD	D. D. Bibler	Present	Present
HANCOCK	Lawrence H. Goodman	Present	-----
	M. Wesley Feigert	-----	Present
HARDIN	Wendell I. Zaring	Present	Present
LOGAN	Hobart L. Mikesell	Present	Present
MARION	Merritt K. Marshall	Present	Present
MERCER	George H. McIlroy	Present	-----
SENECA	Walter A. Daniel	-----	Present
VAN WERT	Edwin Wm. Burnes	Present	Present
WYANDOT	K. K. Solacoff	Present	Present
FOURTH DISTRICT			
DEFIANCE	Francis Lenhart	-----	Present
FULTON	Benjamin Reed, Jr.	Present	Present
HENRY	Thomas F. Tabler	Present	Present
LUCAS	Edmond F. Glow	Present	Present
	William G. Henry	-----	Present
	J. Lester Kobacker	Present	Present
	Adelbert J. Kuehn	Present	Present
	Frederick P. Osgood	Present	Present
	Frank F. A. Rawling	Present	Present
	Howard E. Smith	Present	-----
	Patrick Hughes	Present	Present
OTTAWA	D. E. Farling	Present	Present
PAULDING	Milo B. Rice	Present	Present
PUTNAM	Richard Wilson	Present	Present
SANDUSKY			
WILLIAMS			
WOOD	Robert A. Peatee	-----	Present
	William H. Roberts	Present	-----
FIFTH DISTRICT			
ASHTABULA	James O. Barr	Present	Present
CUYAHOGA	Joseph L. Bilton	-----	Present
	Francis L. Browning	-----	Present
	John H. Budd	Present	Present
	Christopher A. Colombi	Present	Present
	E. H. Crawfis	Present	Present
	Henry A. Crawford	Present	Present
	Russell B. Crawford	Present	Present
	Nicholas DePiero	Present	Present
	Eduard Eichner	Present	Present
	Eugene A. Ferreri	Present	Present
	Harry A. Haller	Present	Present
	H. D. Iler	Present	Present

County	Delegate	First Session	Second Session
GEAUGA LAKE	Chester R. Jablonoski	Present	Present
	Fred R. Kelly	Present	Present
	John A. Kenney, Jr.	Present	Present
	M. H. Lambright, Jr.	-----	Present
	Paul A. Mielcarek	Present	Present
	Russell P. Rizzo	Present	Present
	Philip J. Robecheck	Present	Present
	A. B. Schneider, Jr.	Present	Present
	Hubert E. Shafer	Present	Present
	Benjamin S. Park	-----	Present
SIXTH DISTRICT			
COLUMBIANA MAHONING	John A. Fraser	Present	Present
	G. E. DeCicco	Present	Present
	Paul J. Mahar	-----	Present
	John J. McDonough	-----	Present
PORTAGE STARK	H. P. McGregor	Present	Present
	Myron W. Thomas	Present	Present
	Mark G. Herbst	-----	Present
	Maurice F. Lieber	Present	-----
SUMMIT	John R. Seesholtz	Present	Present
	J. B. Walker	Present	Present
	William White, Jr.	Present	Present
	Philip B. deMaine	Present	Present
	Walter A. Hoyt, Jr.	Present	Present
	Donald I. Minnig	Present	Present
	Geo. Kenneth Parke	Present	Present
	Ross R. Zeno	Present	Present
	E. G. Caskey	-----	Present
	Densmore Thomas	Present	-----
TRUMBULL	R. H. Ralston	Present	Present
SEVENTH DISTRICT			
BELMONT CARROLL	B. C. Diefenbach	Present	Present
	Carl A. Lincke	-----	Present
COSHOCTON HARRISON JEFFERSON MONROE TUSCARAWAS	Samuel L. Weir	Present	-----
	J. Clifford Briner	Present	Present
	G. E. Henderson	Present	Present
	Carl F. Goll	Present	Present
	Joseph W. Hamilton	Present	Present
EIGHTH DISTRICT			
ATHENS FAIRFIELD GUERNSEY LICKING MORGAN MUSKINGUM NOBLE PERRY WASHINGTON	Don R. Johnson	Present	-----
	Jack L. Kraker	Present	Present
	James A. L. Toland	Present	Present
	Warren N. Koontz	Present	Present
	Henry Bachman	Present	Present
	Earl R. Haynes	Present	-----
	Kenneth E. Bennett	-----	Present
NINTH DISTRICT			
GALLIA HOCKING JACKSON LAWRENCE MEIGS PIKE SCIOTO VINTON	Keith R. Brandeberry	Present	Present
	C. C. Fitzpatrick	Present	Present
	Harry Nenni	Present	Present
	Roger P. Daniels	Present	Present
	Robert M. Andre	Present	Present
	William M. Singleton	Present	Present
	H. D. Chamberlain	Present	Present
TENTH DISTRICT			
DELAWARE FAYETTE FRANKLIN	Tennysen Williams	Present	Present
	J. H. Persinger	Present	-----
	Drew J. Arnold	Present	Present
	Thomas R. Curran	-----	Present
	Mel A. Davis	Present	-----
	James C. Good	-----	Present
	Philip B. Hardymon	Present	Present
	Edward W. Harris	Present	-----
	Reuben B. Hoover	Present	Present
	Charles W. Pavey	Present	Present
KNOX MADISON MORROW PICKAWAY ROSS UNION	Donald J. Vincent	Present	Present
	Judson D. Wilson	Present	Present
	Henry T. Lapp	Present	Present
	Sol Maggied	Present	Present
	Joseph P. Ingmire	Present	Present
	Edward L. Montgomery	Present	Present
	Robert E. Swank	Present	Present
	E. J. Marsh	Present	Present
ELEVENTH DISTRICT			
ASHLAND ERIE HOLMES HURON LORAIN MEDINA RICHLAND WAYNE	E. J. Meckstroth	Present	Present
	Neven P. Stauffer	Present	Present
	O. J. Nicholson	Present	Present
	James T. Stephens	Present	Present
	George R. Wiseman	Present	Present
	Nevin J. M. Klotz	Present	Present
	Charles F. Curtiss	Present	Present
	Harry Wain	Present	Present
	Albert B. Huff	-----	Present

(Continued on Next Page)

(House Roll Call — Continued)

County	Delegate	First Session	Second Session
OFFICERS			
President	G. A. Woodhouse	Present	Present
President-Elect	Frank H. Mayfield	Present	Present
Past-President	Robert S. Martin	Present	Present
Treasurer	Geo. J. Hamwi	Present	Present
COUNCILORS			
District			
First	Charles W. Hoyt	Present	Present
Second	R. Dean Dooley	Present	Present
Third	Floyd M. Elliott	Present	Present
Fourth	Paul F. Orr	Present	Present
Fifth	George W. Petznick	Present	Present
Sixth	C. A. Gustafson	Present	Present
Seventh	Robert E. Hopkins	Present	Present
Eighth	William D. Monger	Present	Present
Ninth	C. L. Pitcher	Present	Present
Tenth	Edwin H. Artman	Present	Present
Eleventh	H. T. Pease	Present	Present
Totals		140	153

Licensed Through Endorsement by State Medical Board

The State Medical Board of Ohio has issued licenses to practice medicine and surgery in the State to the following physicians through endorsement of their licenses to practice in other states, or certification by the National Board of Medical Examiners (included are intended residence and medical school of graduation):

February 3—Gene V. Bogaty, Cleveland, Univ. of Pennsylvania; Richard C. Byron, Columbus, Johns Hopkins Univ.; Robert C. Edmondson, Cleveland, Univ. of Wisconsin; Adnan F. Kalfaoglu, Ankara University, Turkey; Vincente M. Valls, Gallipolis, Univ. of Valencia, Spain; Ramendra K. Das, Troy, Calcutta Medical College, India.

April 7—Isabelle B. Ackles, Akron, Cornell Univ.; Carl L. Armstrong, Toledo, Meharry Medical College; William C. Bailey, Columbus, Wayne State Univ.; Delbert D. Blickenstaff, Versailles, Univ. of Oregon; John M. Brandon, Cleveland, Univ. of Pittsburgh; Joseph Brinz, Univ. of Santo Domingo, Dominican Republic; Edward T. Buford, Jr., Cincinnati, Meharry Medical College; Wendell M. Burns, Dayton, Univ. of Louisville;

Alex G. Carabia, Univ. of Havana, Cuba; Gordon R. Evans, Cleveland, Univ. of Utah; Hubert L. Felger, Univ. of Zagreb, Yugoslavia; F. David Fisher, Univ. of Rochester; Alvin R. Frank, Cincinnati, Univ. of Illinois; Robert E. Goynes, Upper Sandusky, College of Medical Evangelists; Seldon R. Graham, Cincinnati, New York Medical College; Albert Grish, Univ. of Bern, Switzerland;

George C. Hale, Sr., Cincinnati, Meharry Medical College; Robert P. Hardwig, Lorain, State University of Iowa; Harold J. Hassel, Brookfield, Jefferson Medical College; Don F. Hatten, Gallipolis, Medical College of Virginia; Adrian R. Jensen, Dayton, Univ. of Minnesota; David W.

Narcotics Registration Must Be Renewed by July 1

On or before July 1, every physician registered under the Harrison Narcotic Act, must (unless he is in military service) re-register with the Director of Internal Revenue of the district in which he maintains an office and pay the Federal Narcotic Tax of \$1. Initial application may be made at any time, but existing permits must be renewed on or before July 1, annually.

Form 678 has been mailed by the Narcotics Division to physicians on record. But the physician is responsible for re-registering whether or not he receives a form. A penalty is incurred by those who fail to re-register before deadline. Gross violations of the Narcotic Act are punishable by heavy fines and imprisonment.

Physicians who administer, dispense or prescribe cannabis must obtain a special permit under the Marihuana Tax Act and pay an additional tax of \$1.

Johnson, Loveland, Tufts Univ.; William W. Johnson, Northwestern Univ.;

Frank F. Kaiser, Jr., Circleville, New York Univ.; Herman L. Kamenetz, Univ. of Paris, France; Robert E. Kellum, Cleveland, Univ. of Colorado; Arvin J. Klein, Columbus, State Univ. of New York; Joseph L. Kloss, Akron, St. Louis Univ.; Frank J. Kocab, Cleveland, St. Louis Univ.; Michael Kulick, Cleveland, Marquette Univ.;

Barry Lauton, Cleveland, New York Univ.; Edward M. Lees, Cleveland, Univ. of Geneva, Switzerland; Ralph McGraw, New York University; Bernard G. Miklos, Cleveland, Univ. of Pittsburgh; James A. O'Neill, Columbus, St. Louis Univ.; Ann H. Oyer, Middletown, Woman's Medical College of Pennsylvania;

Alan D. Randall, Columbus, Tufts Univ.; Jerome Ratzan, Univ. of Geneva, Switzerland; Robert M. Runge, Cincinnati, Univ. of Louisville; John A. Schietzelt, Cleveland, State Univ. of Iowa; John J. Sinnott, Dayton, St. Louis Univ.; Don K. Snyder, Payne, Northwestern Univ.; Thomas R. Soehnen, Brewster, St. Louis Univ.; Sheldon D. Stern, Cleveland, Indiana University; John R. Sylvester, Cleveland, Temple Univ.;

August J. Vana, Cleveland, Stritch School of Med. of Loyola Univ.; George J. Vareska, Maple Heights, Univ. of Debrecen, Hungary; Elisabeth B. Ward, Cleveland, Woman's Medical College of Pennsylvania; Robert J. E. Zechnich, Cincinnati, State Univ. of New York.

Annual Meeting Attendance . . .

Nearly 2100 Physicians and Medical Students Attend 1959 Session in Columbus; Total Registration, 3182; Names of Members Present Given

AN EXCELLENT attendance was recorded at the 1959 Annual Meeting in Columbus. The total registration was 3182, which included 1652 physicians and 445 medical students.

The actual breakdown of figures recorded at the registration desk is as follows: Members of the Association, 1359; interns, residents and Ohio guest physicians, 214; out-of-state guest physicians, 79; medical students, 445; scientific exhibitors other than OSMA members, 31; technical exhibitors, 333; miscellaneous guests including nurses, technicians, dentists, etc., 393; members of the Woman's Auxiliary, 328; total 3182.

Following are registration figures for members of the Association by counties, a comparison of Annual Meeting attendance figures 1919 through 1959, and a roster of members who registered:

Registration, 1959 Annual Meeting by Counties and Membership Data

County	Total Membership		Annual Meeting Registration
	Dec. 31, 1958	April 16, 1959	
Adams	11	9	1
Allen	113	113	23
Ashland	27	26	8
Ashtabula	56	54	1
Athens	34	35	7
Auglaize	19	16	3
Belmont	55	58	10
Brown	13	12	1
Butler	164	160	12
Carroll	11	11	2
Champaign	14	15	4
Clark	124	118	21
Clermont	25	27	3
Clinton	25	24	9
Columbiana	76	63	7
Coshocton	22	22	7
Crawford	35	35	9
Cuyahoga	2120	1955	99
Darke	28	26	8
Defiance	19	15	1
Delaware	26	24	10
Erie	62	60	12
Fairfield	50	50	21
Fayette	16	16	5
Franklin	848	755	341
Fulton	24	23	2
Gallia	35	31	6
Geauga	10	11	2
Greene	44	41	9
Guernsey	34	30	6
Hamilton	1186	1132	93
Hancock	43	43	5
Hardin	26	23	6
Harrison	13	11	3
Henry	14	15	1
Highland	20	13	8
Hocking	12	12	4
Holmes	9	9	4
Huron	27	27	8
Jackson	17	14	3
Jefferson	61	45	7
Knox	33	32	11
Lake	66	70	4
Lawrence	28	26	6
Licking	60	59	22
Logan	25	23	12
Lorain	156	152	22
Lucas	575	526	38
Madison	13	13	3
Mahoning	310	318	24
Marion	61	51	13
Medina	41	41	12
Meigs	9	7	1
Mercer	21	21	4
Miami	58	55	16
Monroe	2	4	0

Registration, 1959 Annual Meeting by Counties and Membership Data

County	Total Membership		Annual Meeting Registration
	Dec. 31, 1958	April 16, 1959	
Montgomery	492	460	86
Morgan	5	4	2
Morrow	9	9	6
Muskingum	65	59	17
Noble	4	4	1
Ottawa	20	18	5
Paulding	8	9	2
Perry	12	12	4
Pickaway	16	14	4
Pike	10	8	3
Portage	44	47	7
Preble	10	10	1
Putnam	13	13	4
Richland	109	108	27
Ross	47	46	26
Sandusky	43	40	6
Scioto	76	74	26
Seneca	43	41	14
Shelby	17	19	9
Stark	328	310	27
Summit	455	455	27
Trumbull	119	117	12
Tuscarawas	58	55	22
Union	17	14	6
Van Wert	16	17	4
Vinton	2	1	1
Warren	17	17	4
Washington	31	17	7
Wayne	53	50	8
Williams	17	17	1
Wood	38	38	5
Wyandot	14	12	5
Totals	9234	8697	1359

ANNUAL MEETING REGISTRATION FOR 1919-1959 INCLUSIVE

Year	Place	Members	Guest Physicians	Medical Students	Woman's Aux.; Misc. Guests	Sc. and Tech. Exhibitors	Total
1919	Columbus	1173			261	92	1539
1920	Toledo	860			105	80	1062
1921	Columbus	1275			104	96	1503
1922	Cincinnati	1066			184	70	1341
1923	Dayton	1117			202	76	1414
1924	Cleveland	1301			180	109	1603
1925	Columbus	1204			361	107	1689
1926	Toledo	903			120	83	1125
1927	Columbus	1320			286	82	1705
1928	Cincinnati	916			92	80	1115
1929	Cleveland	1231			249	124	1619
1930	Columbus	1241			435	86	1775
1931	Toledo	826			198	50	1087
1932	Dayton	978			201	45	1226
1933	Akron	858			160	25	1049
1934	Columbus	1069			410	51	1539
1935	Cincinnati	973			197	84	1271
1936	Cleveland	1099			563	137	1813
1937	Dayton	1103			366	64	1551
1938	Columbus	1330			619	104	2068
1939	Toledo	1056			271	84	1426
1940	Cincinnati	1126			323	114	1589
1941	Cleveland	Joint Meeting with A. M. A.					
1942	Columbus	1221			527	119	1880
1943	Columbus	544			160		717
1944	Columbus	830			441	130	1421
1945	No Meeting						
1946	Columbus	1262	130	65	507	157	2121
1947	Cleveland	1502	158	15	411	328	2414
1948	Cincinnati	1362	293	27	491	214	2387
1949	Columbus	1533	162	221	462	230	2608
1950	Cleveland	1587	260	102	707	376	3032
1951	Cincinnati	1208	162	185	647	352	2554
1952	Cleveland	1366	204	49	687	395	2701
1953	Cincinnati	1155	180	224	578	298	2435
1954	Columbus	1222	197	173	701	252	2545
1955	Cincinnati	1360	211	184	738	317	2810
1956	Cleveland	1601	338	120	1029	489	3577
1957	Columbus	1164	149	320	689	368	2690
1958	Cincinnati	1327	164	45	674	325	2535
1959	Columbus	1359	293	445	721	364	3182

MEMBERS OF THE STATE ASSOCIATION REGISTERED AT THE 1959 MEETING

Adams County—Hazel W. Sproull.

Allen County—John D. Albertson, Dwight L. Becker, Margaret E. Belt, Fred P. Berlin, Charles L. Blumstein, Raymond B. Croissant, Homer G. Deerhake, F. Miles Flickinger, Bernard Glass, Kenneth G. Hawver, John D. Hubbell, John P. Kempf, Walter A. Noble, Alex C. Reed, Franklin D. Rodabaugh, Joanna J. Rodziewicz, Maurice E. Scheetz, David L. Steiner, Roger L. Tecklenberg, John F. Tillotson, Boyd W. Travis, Harry Warshawsky, Carl H. Zinsmeister.

Ashland County—John W. Coles, Paul E. Kellogg, Charles H. McMuller, C. Glenn Paisley, Hiram P. Petty, Paul J. Sauder, Wayne C. Smith, John M. Strait.

Ashtabula County—Vita Draulis.

Athens County—Allan A. Baldwin, Wolford Baumgaertel, Arthur L. Dobosiewicz, Hubert H. Fockler, Don R. Johnson, T. J. Najm, Beatrice Postle.

Auglaize County—Elizabeth Y. Kuffner, Robert S. Oyer, T. H. Will.

Belmont County—John A. Brown, Leo D. Covert, Benjamin C. Diefenbach, Milton D. Levine, Lewis L. Liggett, Heinz Lord, Harvey H. Murphy, R. A. Raimonde, Homer E. Ring, F. P. Sutherland.

Brown County—John R. Donohoo.

Butler County—John A. Carter, E. B. Cunningham, David M. Gerber, Jack L. Harris, William H. Henry, Henry A. Long, Neil Millikin, Martin Rush, Louis H. Skimming, Clyde I. Stafford, Robert M. Wilson, Alexander Witkow.

Carroll County—Carl A. Lincke, Samuel L. Weir.

Champaign County—Victor R. Frederick, Isador Miller, John K. Pond, Theodore E. Richards.

Clark County—Frank W. Anzinger, Edwin E. Ash, Robert B. Beam, Harry M. Berley, John A. Davidson, James G. Gianakopoulos, Max D. Graves, G. E. Heinrich, Dorothy C. V. Heinz, George R. Horton, Clarence W. Hullinger, Morris B. Martin, Cecil D. McIntire, William H. Miller, Lincoln L. Moore, Edward L. Ringer, Geneva L. Shong Rothemund, Elliott W. Schilke, J. Harold Shanklin, Ray M. Turner, Ernest H. Winterhoff.

Clermont County—Phillips F. Greene, Carl Minning, F. S. Skeen.

Clinton County—Foster J. Boyd, Jr., Mary R. Boyd, Robert Conard, Roy D. Goodwin, Kelley

Hale, Nathan S. Hale, William L. Wead, John K. Williams, Edmond K. Yantes.

Columbiana County—Wade A. Bacon, William S. Banfield, H. Lee Bookwalter, Frederick R. Crowgey, John A. Fraser, Virgil C. Hart, R. T. Holzbach.

Coshocton County—Milton A. Boyd, J. Clifford Briner, Floyd W. Craig, Robert E. Hopkins, Alfred P. Magness, Howard H. Schwindt, Lewis E. Smith.

Crawford County—Clarence Adams, Jack W. Arnold, Darrel D. Bibler, Gerald E. Blanchard, Arnold Eicens, Carl J. Ide, Gotholds Kalnins, Theodore D. Sawyer, Donald R. Wenner.

Cuyahoga County—Angela B. Adams, Ward M. Athey, James O. Barr, Garry G. Bassett, John D. Battle, Jr., James E. Bennett, William R. Biddlestone, Joseph L. Bilton, Francis L. Browning, John H. Budd, Frank H. Clark, Christopher A. Colombi, Ewing H. Crawfis, Henry A. Crawford, Russell B. Crawford, Leon H. Dembo, Nicholas G. DePiero, Fred W. Dixon, Harriet P. Dustan, Albert H. Dyson, Jr., Robert H. Ebert, Eduard Eichner, Oliver Eitzen, A. Carlton Ernstene, Eugene A. Ferreri,

W. James Gardner, Donald M. Glover, Harry Goldblatt, Vernon D. Hacker, Lawrence T. Hadbavny, Donald E. Hale, Harry A. Haller, John R. Hannan, Joseph F. Hattenbach, James S. Hewlett, Robert A. Hingson, Stanley O. Hoerr, Charles L. Hudson, Alfred W. Humphries, Harris D. Iler, H. F. Inderlied, C. R. Jablonoski, Harold B. Jackson,

Earle B. Kay, Fred R. Kelly, John A. Kenney, Jr., John W. King, Willem J. Kolff, James S. Krieger, Vincent T. LaMaida, M. H. Lambright, Jr., Albert C. Lammert, Charles L. Leedham, Walter H. Maloney, John G. Margrett, John W. Martin, Julius W. McCall, Charles Q. McClelland, Joseph D. McNerney, Harvey J. Mendelsohn, Paul A. Mielcarek, Nicholas Misischia, Sylvester C. Missal, Juan H. Montier, Paul A. Nelson, Richard M. Nelson, Anthony J. Perko, Irwin N. Perr, George W. Petznick, Josephine Dirion - Phillips, Louis Pillersdorf, J. K. Potter, Albert M. Potts,

Charles H. Rammelkamp, Jr., C. Jackson Rayburn, Joseph H. Rayner, Russell P. Rizzo, P. J. Robeck, Ralph S. Rosewater, Edward C. Roy, Filmore Schiller, A. Benedict Schneider, Mildred H. Shelly, F. A. Simeone, William Sinclair, Penn G. Skillern, John C. Starling, John P. Storaasil,

(Continued on Page 854)

Officials and Distinguished Guests at Banquet



The "official family" of the Association with wives and distinguished guests occupied a number of tables as well as the speakers' table. Here are candid shots of some of these groups.

(Members Who Attended Annual
Meeting—Cont'd.)

Shelley M. Strain, Howard P. Taylor, Warner W. Tuckerman, Rupert B. Turnbull, Samuel L. Vinci, David Volk, Elden C. Weckesser, Daniel E. Wertman, Clay W. Whitaker, Guy H. Williams, Jr., Henry A. Zimmerman.

Darke County—John R. Alley, E. Westbrook Browne, Jesse L. Heise, Maurice M. Kane, Lowell D. Mann, John S. Meyers, Peter H. Mulder, Robert V. Wade.

Defiance County—Francis M. Lenhart.

Delaware County—Adelbert R. Callander, Harold W. Davis, Laurence M. Ihle, Irene L. Lazdins, Max W. Livingston, Francis W. Logan, Douglas L. Smith, William L. Vogt, Charles E. Ward, Tennyson Williams.

Erie County—Wm. F. Burger, Edward P. Gillette, Jr., Ross M. Knoble, Paul S. LaFollette, Clinton F. Lavender, Eugene J. Martos, Emil J. Meckstroth, Gordon F. Ogram, Lester G. Parker, Paul N. Squire, Sigismund Vechey, Richard H. Williamson.

Fairfield County—R. S. Bode, Charles F. Clark, Adam D. Echert, Andrew C. Essman, Pauline E. Garber, Stephen R. Hodsdon, William S. Jasper, George F. Jones, Victor N. Kistler, Jack L. Kraker, George W. LeSar, Elson D. McCullough, William D. Monger, Galon S. Rodabaugh, Edward B. Roller, Harold J. Schwendeman, Chester P. Swett, Kenneth W. Taylor, Lewis H. Urling, Richard A. Welsh, Robert E. Whetstone.

Fayette County—Robert U. Anderson, Philip E. Binzel, Joseph M. Herbert, Jack H. Persinger, Byers W. Shaw.

Franklin County—B. W. Abramson, Louis Adelman, Tibor Agoston, Louise P. Ainsworth, Marion L. Ainsworth, Donald J. Alspaugh, James M. Andrew, Neil C. Andrews, Willard B. Andrus, Elizabeth R. Aplin, Drew J. Arnold, John E. Arthur, William F. Ashe, Perry R. Ayres,

Frederik S. Barends, Walter Baum, Earl H. Baxter, Harry C. A. Beach, James F. Beattie, George E. Bell, Floyd M. Beman, Henry Bergman, Herbert G. Birck, Rozier E. Bland, William R. Blesch, Walter C. Boenheim, E. Thomas Boles, Jr., John P. Bolton, George H. Bonnell, Jr., R. W. Bonnell, Joseph A. Bonta, Jack R. Bontley, H. E. Boucher, Charles F. Bowen, Wade D. Bower, Donald F. Bowers, Joseph R. Boyle, Norman Scott Brandes, Richard I. Brashear, Gill W. Brehm, Wayne Brehm, Thomas H. Brewer, Bernard J. Brief, John E. Briggs, Grace Nunemaker Brown, John Q. Brown, Robert H. Browning,

Roderick A. Bryce, Gail W. Burrier, Jonathan G. Busby, Alice M. Bustin, Richard B. Butler, Jr.,

Arthur M. Call, William R. Calland, Benjamin Caplan, William H. Carter, Lewis W. Cellio, H. Wm. Clatworthy, Jr., H. M. Clodfelter, George D. Clouse, Oscar L. Coddington, Arthur R. Cohen, George W. Cooperrider, William E. Copeland, Dorence S. Cowles, John N. Cross, Thomas R. Curran,

Robert F. Daly, Horace B. Davidson, Drew L. Davies, Dwight H. Davies, Mel A. Davis, William W. Davis, Charles J. Deishley, G. Walter DeLaMotte, C. J. Delor, Dale R. Dickens, Frederick W. Dierker, Paul H. Dillahunt, Lowell O. Dillon, Bertram D. Dinman, Charles A. Doan, R. Frank Donley, J. Quinn Dorgan, Francis W. Eberly, Ray E. Ebert, Charles W. Edwards, Jesse Eisen, Nathan P. Eisenberg, Dan W. Elliott, Matthew W. Elson, Herbert D. Emswiler, Herbert K. Ervin, Harry E. Ezell,

Willard B. Fernald, Jerome Fisher, Rivington H. Fisher, Thurman R. Fletcher, Frederick A. Flory, Jonathan Forman, Joseph C. Forrester, Thomas E. Fox, Frank C. Frailie, Lewis T. Franklin II, Robert L. Friedman, Wesley Furste, Clarence M. Gallagher, Francis T. Gallen, Helmut H. Gante, John Gersten, Howard D. Giles, James C. Good, Emilie C. Gorrell, Norman E. Goulder, Grant O. Graves, John B. Gravis, Floyd M. Green, Paul E. Grimm,

Robert A. Haines, Fred E. Hall, William L. Hall, Edwin B. Hamilton, Geo. T. Hamwi, Dorence O. Hankinson, Robert J. Hansell, James A. Hardie, Frances K. Harding, George T. Harding, Philip B. Hardyman, Edward W. Harris, William B. Harris, Margot D. Hartmann, Wm. H. Haver, Robert A. Heilman, Eldred B. Heisel, Gabriel C. Heller, Hobart R. Helman, J. L. Henry, David K. Heydinger, John E. Hoberg, Willis H. Hodges, Jr., George R. Hoeflinger, Julius Hoffman, Walter A. Holbrook, Zeph J. R. Hollenbeck, John H. Holzaepfel, Reuben B. Hoover, Wm. H. R. Howard, Raymond B. Hudson, Franklin C. Hugenberger, George K. Hughes, Harold I. Humphrey, John K. Humphries, Wm. E. Hunt, Brooks H. Hurd, Rodney B. Hurl, William G. Hutchinson, Thomas R. Huxtable, Jr.,

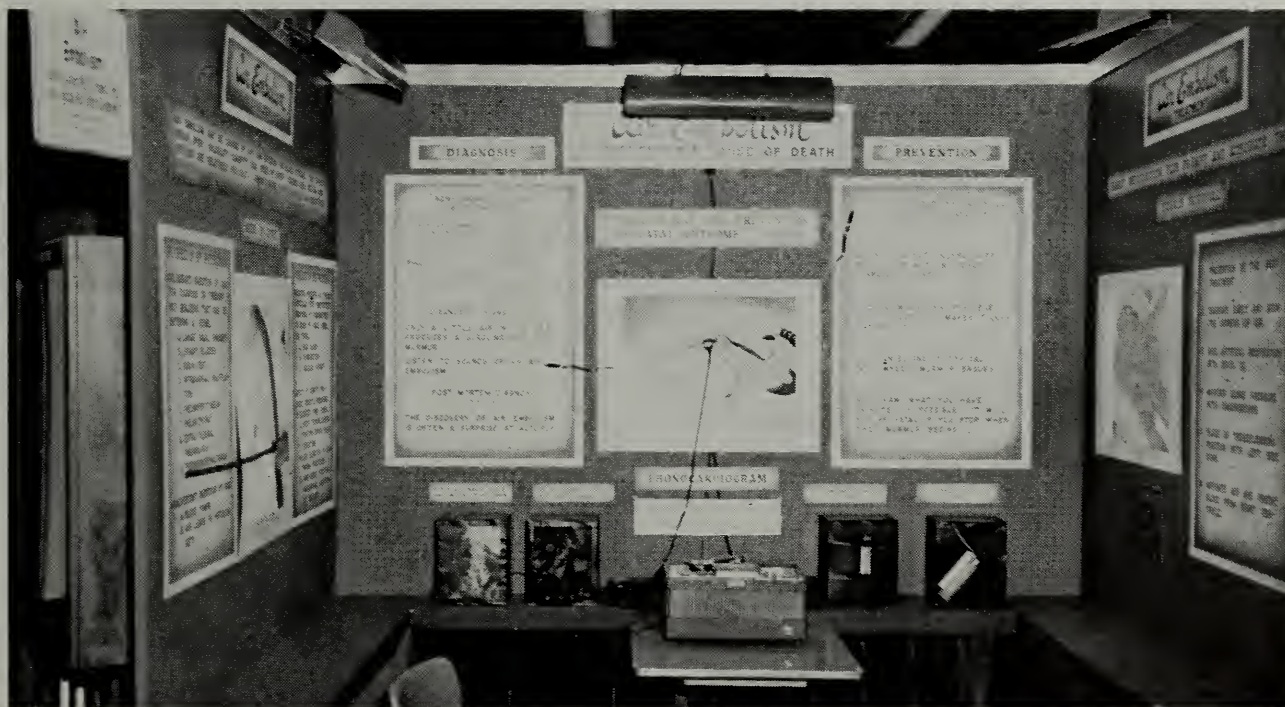
Lester E. Imboden, Robert M. Inglis, Carl W. Iuler, Arthur G. James, Raymond L. Jennings, Ralph J. Johansmann, Ernest W. Johnson, Charles E. Johnston, Alfred L. Joseph, Abraham H. Kanter, Max P. Kanter, Henry W. Karrer, James R. Kauffman, Robert A. Kidd, Jr., C. C. Kirk, Gilman D. Kirk, Robert C. Kirk, Calvin B. Kitchen, Karl P. Klassen, Edmond G. Klopfer, Phillip T. Knies,

(Continued on Next Page)

These Received Special Recognition Among Exhibits



A Special Award was presented for this exhibit on "Restoration of Pinch in the Severely Injured Hand."



This exhibit entitled "Air Embolism" was given the Bronze Award in the teaching field.

Joseph Kosar, Albert Kostoff, George O. Kress, Willis T. Kubiak, Robert H. Kuhn, Henry B. Lacey, Frank Lacksen, Frank L. Lally, Cornelius C. Landen, Hedwig D. Lang, C. M. Larrick, Ruskin B. Lawyer, Harry E. LeFever, Warren H. Leimbach, Paul W. Leithart, Norris E. Lenahan, H. J. Leuchter, David R. Lewis, Tom F. Lewis,

James W. Long, Roland E. Long, Otto J. Lowy, W. Beele Lutz,

Joseph Macys, Robert H. Magnuson, Torrence A. Makley, Roy E. Manning, Jack Marks, C. R. Markwood, Robert L. Marshall, George T. Mathews, James E. Matson, Charles R. McClave,

(Continued on Next Page)

(Members Who Attended Annual
Meeting—Cont'd.)

A. F. McCoy, Richard L. McFarland, Charles W. McGavran, Charles W. McGavran, II, John N. Meagher, Russel G. Means, Charles V. Meckstroth, Richard L. Meiling, William B. Merryman, Paul S. Metzger, Paul D. Meyer, Ronald A. Mezger, Nicholas Michael, Geo. F. Millay, Paul R. Miller, Howard R. Mitchell, Howard R. Mitchell, Jr., William F. Mitchell, William Molnar, James R. Monroe, William B. Morrison, Jacob Moses, Link M. Murphy, Ernest M. Newkirk, Harry O. Newland, James W. Norris, Walter E. Obetz, Anton W. Oelgoetz, Thomas K. Oliver, Jr.,

Munroe W. Palestrant, Ralph M. Patterson, Carey B. Paul, Jr., William D. Paul, William T. Paul, Charles W. Pavey, Claude S. Perry, Irving Pine, H. M. Platter, Thomas C. Pomeroy, Leonard Primanis, John A. Prior, Clark P. Pritchett, Allen D. Puppel, I. Darin Puppel, Dale E. Putnam, Robert F. Rauch, Robert L. Reinhart, Richard H. Retter, William G. Rice, Mary C. Richards, John H. Richardson, John P. Riepenhoff, William O. Robertson, Jr., Rush Robinson, Samuel W. Robinson, A. Sophie Rogers, Philip C. Rond, Jr., John H. Rosemond, Jr., LeaBelle I. Ross, Carl W. Roth, Henry A. Rowe, Nellija O. Rubenis, Richard D. Ruffin, Anthony Ruppersberg, Jr., Earl H. Ryan,

Werner E. Samlowski, Ralph B. Samson, William H. Saunders, Martin P. Sayers, Mark L. Saylor, James F. Schieve, Gerald G. Schreiber, Edward R. Schumacher, Harry E. Secrest, Roy J. Secrest, Thomas E. Shaffer, Alvin D. Shelton, C. C. Sherburne, Wynne M. Silbernagel, Howard D. Sirak, Clayton S. Smith, William A. Smith, William P. Smith, Robert R. Sommer, Ollie E. Southard, Pearl C. Staker, Edwin J. Stedem, Robert B. Stevenson, Walter M. Stout,

Mabel R. Tarbell, Wells H. Teachnor, S. J. Telerski, Chris B. Theodotou, Walter A. Thomas, John R. Thompson, Eliere, J. Tolan, Joseph F. Tomashefski, Harry W. Topolosky, Donald W. Traphagen, Gwendolyn C. Trudeau, Lawrence E. Turton, John P. Urban, Ludolph H. Van der Hoeven, Donald J. Vincent, Robert E. Visintine, Emmerich von Haam,

Watson H. Walker, Thomas P. Wangler, Harold W. Ward, Robert N. Watman, Wilburn H. Weddington, Damon E. Wetterauer, W. E. Wheeler, John A. Whieldon, Joseph P. Whitlatch, James E. Williams, James H. Williams, Roger D. Williams, Benjamin F. Wills, Eugene I. Wilson, Henry E. Wilson, Judson D. Wilson, Charlotte Winnemore, Harvey D. Wright, Carolyn H. Zieg-

ler, John B. Ziegler, Richard W. Zollinger, Robert M. Zollinger, Maurice L. Zox.

Fulton County—Clarence F. Murbach, Ben H. Reed, Jr.

Gallia County—Keith R. Brandeberry, W. Lewis Brown, Arthur R. Fleming, Thomas W. Morgan, Walter S. Price, Francis W. Shane.

Geauga County—Alton W. Behm, Hubert E. Shafer.

Greene County—Ray W. Barry, Paul D. Espey, Robert D. Hendrickson, Carl D. Hyde, Donald F. Kyle, Clarence G. McPherson, Joseph R. Schauer, John D. Tharp, Theodore H. Winans.

Guernsey County—C. A. Craig, William L. Denny, Jack D. Knapp, Robert A. Ringer, A. Clifton Smith, Jr., James A. L. Toland.

Hamilton County—M. M. Adams, William C. Ahlering, John E. Allen, Arthur O. Bachman, Robert A. Bader, Charles D. Bahl, Charles M. Barrett, Julien E. Benjamin, Byron E. Boyer, Frederick Brockmeier, Clinton H. Buford, Charles O. Carothers, Edmund C. Casey, Harold N. Cavanaugh, William R. Chambers, Edgar M. Corrill, Joseph G. Crotty, Gustave Eckstein, Virginia M. Esselborn, Arthur T. Evans, Edwin C. Faessler, Carroll J. Fair, Albert J. Farrell, J. Philip Fox, Kenneth A. J. Frederick,

Alfred S. Gardiner, Paul G. Geiss, Nicholas J. Giannestras, Ralph W. Good, J. Victor Greenebaum, Albert L. Haas, O. Warren Hattendorf, John W. Hauser, Benjamin L. Hawkins, J. Robert Hawkins, George B. Haydon, Joseph D. Heiman, Harry K. Hines, Stephen P. Hogg, Richard B. Homan, Robert E. Howard, Paul Hoxworth, Charles W. Hoyt, J. Robert Hudson, Hope Hyams, Donald L. Jacobs, Daniel V. Jones,

Elmer G. Katz, Sidney A. Kay, H. H. Kohler, Herman J. Kooiker, Lloyd E. Larrick, H. W. Lawrence, Henri LeClaire, Frank H. Mayfield, James M. McCord, Henrietta Marie Miller, William A. Moore, James A. L. Moulton, J. Roger Newstedt, Dale P. Osborn, Evalyn M. Partymiller, Charles L. Pfeiffer, James D. Phinney, Alex Pohowsky, Jr., Andrew C. Renz, Clyde S. Roof, Brigitte R. Rosenberg, Philip H. Rosenberg, W. Donald Ross, Jack H. Rubinstein, Henry W. Ryder,

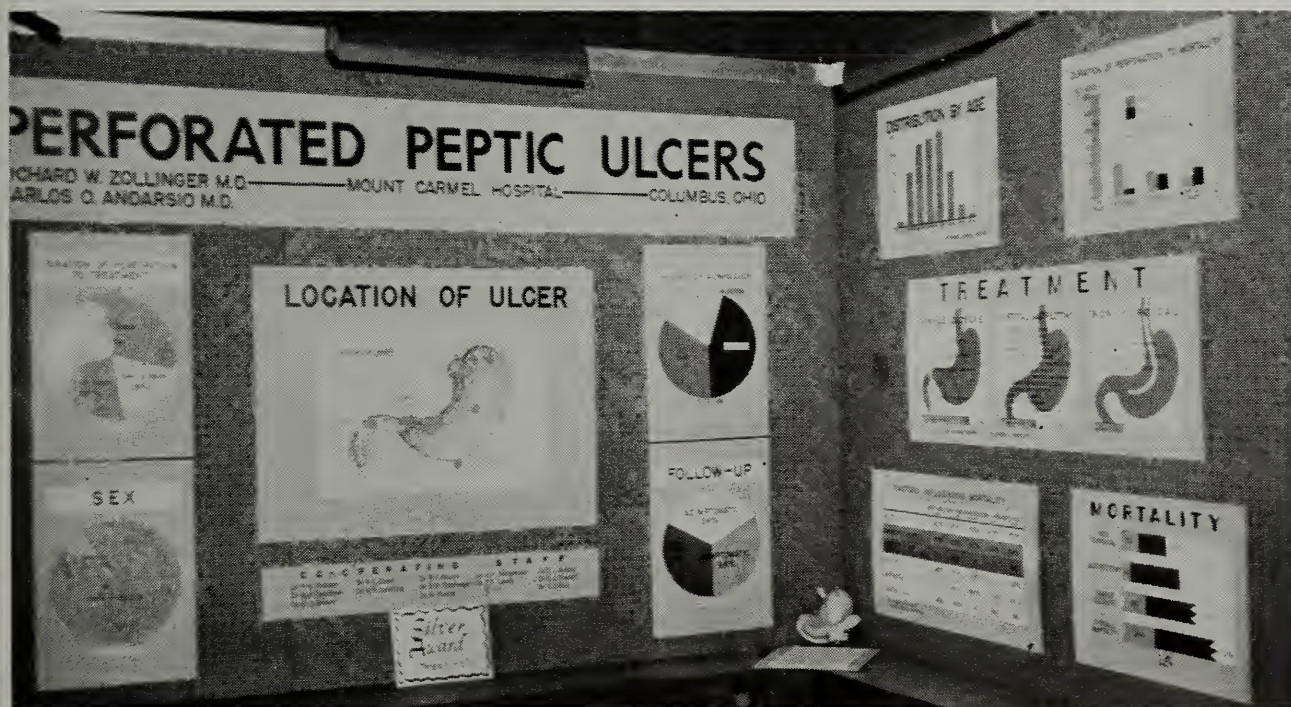
Barnet R. Sakler, William K. Schubert, Bernard Schwartz, Charles A. Sebastian, Denman Shaw, Robert M. Sherman, Dora F. Sonnenday, Arthur H. Spreen, Klaus L. Stemmer, William S. Terwilliger, Clyde S. Thomas, Earl C. VanHorn, Luben S. Walchef, Calvin F. Warner, Philip Wasserman, Henry E. Wedig, Foster M. Williams, Joseph N. Wilson, Carl A. Wilzbach, Charles E. Work, Max M. Zinninger.

(Continued on Next Page)

Two More Award Winning Exhibits



This exhibit won the Bronze Award in the field of original investigation for its portrayal of the "Problems of Sex Determination."



The Silver Award in the field of medical teaching went to this exhibit entitled "Perforated Peptic Ulcers."

Hancock County—Harold O. Crosby, C. H. Evans, Jr., M. Wesley Feigert, Lawrence H. Goodman, R. Grant Janes.

Hardin County—Stephen P. Churchill, Floyd M. Elliott, Jack C. Lindsey, Robert F. Schultz, Wendell I. Zaring, Robert H. Zeis.

Harrison County—Elias Freeman, G. E. Henderson, Janis Trupovnieks.

Henry County—Thomas F. Tabler.

Highland County—J. C. Bohl, Robert G. Claeys, Walter Felson, Clifford G. Foor, Lena B. M. Holladay, Wm. C. Martindill, Jacob Wacker, Richard C. Wenrick.

Hocking County—Howard M. Boocks, Charles T. Grattidge, Jan S. Matthews, Lethia W. Starr.

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(Members Who Attended Annual
Meeting—Cont'd.)

Holmes County—Charles H. Hart, Luther W. High, Owen F. Patterson, Neven P. Stauffer.

Huron County—John Blackwood, Jr., Nino M. Camardese, Wilfred B. Dodgson, Thomas H. Eaton, John V. Emery, Richard L. Jackson, Otto F. Lanka, Owen J. Nicholson.

Jackson County—Clarence C. Fitzpatrick, John L. Frazer, Claude S. Hambrick.

Jefferson County—Howard W. Brettell, Stanley L. Burkhardt, Jacob R. Cohen, Carl F. Goll, Lambert J. Kerschgens, Sanford Press, Albert E. Winston.

Knox County—Anthony Garlisi, George B. Imhoff, Henry T. Lapp, Raymond S. Lord, Alexander S. Mack, James C. McLarnan, Gordon H. Pumphrey, O. W. Rapp, Irville S. Rian, Richard L. Smythe, Clinton W. Trott.

Lake County—Benjamin S. Park, Ira Ramins, Hellmuth E. Simon, Jerome Wertheimer.

Lawrence County—Leland S. Dillon, John A. Dole, Jr., Leo S. Konieczny, Thomas E. Miller, Harry Nenni, Charles E. Vidt.

Licking County—A. S. Burton, Edward A. Carlin, Elinor T. Christiansen, Geraldine H. Crocker, Gerald A. Erhard, Kurt J. Fleisch, Carl M. Frye, Paul C. Grove, Andrew M. Gulliford, Robert C. Haubrich, Warren N. Koontz, James K. Nealon, Coloman A. Perjessy, Carl L. Peterzilge, Arnold D. Piatt, Ralph E. Pickett, R. G. Plummer, Dale E. Roth, Robert E. Sinclair, Charles F. Sinsabaugh, D. A. Skinner, J. Lloyd Wilder.

Logan County—Douglas W. Beach, Byron B. Blank, Charles A. Browning, Jr., George H. Freetage, Paul E. Hooley, Hobart S. Mikesell, John J. Roget, Joseph G. Springer, John B. Traul, Ralph K. Updegraff, F. Blair Webster, John M. Wolfe.

Lorain County—Theodore Berg, Robert D. Berkebile, Charles J. Cooley, Robert J. Emslie, John Halley, Henry E. Kleinhenz, Harold E. McDonald, Lawrence C. Meredith, Ben V. Myers, Augustine J. Novello, John E. Pettress, Denis A. Radefeld, William J. Ralston, Jr., Warren N. Sheldon, Raymond L. Shilling, Eugene J. Stanton, James T. Stephens, Jeanne H. Stephens, R. A. Styblo, William H. Turner, Kenneth H. Willard, George R. Wiseman.

Lucas County—Richard F. Baer, Paul L. Bell, George T. Booth, Ord W. Burkholder, Donald K. Cameron, Henry D. Cook, Edward L. Doermann, Crawford L. Felker, John P. Gardiner, Edmond F. Glow, Harvey C. Gunderson, William G. Henry, Henry L. Hook, John R. Jones, Bernard

A. Karwowski, Jerome Kimmelman, J. Lester Ko-backer, Rollin W. Kuebbeler, Adelbert J. Kuehn, George H. Lemon, Maurice R. McGarvey, C. W. McNamara, William M. Mewborn, Harry F. Mignerey, Jack W. Millis, Spencer W. Northup, Frederick P. Osgood, Landon L. Palmer, Robert W. Pocotte, Frank F. A. Rawling, Richard L. Schafer, Maurice A. Schnitker, Russell L. Shively, Howard E. Smith, James G. Sullivan, Earl F. Ward, William W. Wiedemann, Donald C. Wilson.

Madison County—Sol Maggied, Martin Markus, Paul G. H. Wolber.

Mahoning County—Benjamin S. Brown, G. E. DeCicco, William J. Flynn, Lawrence H. Getty, James N. Gordon, Stanley L. Grosshandler, C. A. Gustafson, John E. L. Keyes, F. G. Kravec, Paul J. Mahar, John J. McDonough, Harlan P. McGregor, DeForest W. Metcalf, Gordon G. Nelson, Stephen W. Ondash, G. A. Parillo, Arthur Everett Rappoport, Joseph J. Sofranec, William E. Sovik, Myron H. Steinberg, Charles W. Stertzbach, Saul J. Tamarkin, Carl H. Weidenmier, William P. Young.

Marion County—Milton F. Axthelm, Daniel W. Brickley, John W. Bull, Karl H. Feistkorn, Herman E. Karrer, Robert E. Logsdon, Paul E. Lyon, Donald H. MacPherson, Merritt K. Marshall, Frederick T. Merchant, Morten S. Olson, Edward T. Sager, Ransome R. Williams.

Medina County—O. G. Austin, Richard W. Avery, Leroy G. Dalheim, R. F. Fasoli, Thomas N. Geraciotti, William G. Halley, Myra L. Johnson, Nevin J. M. Klotz, Horatio T. Pease, Charles J. Silva, Gertrude E. Warner.

Meigs County—Roger P. Daniels.

Mercer County—Donald R. Fox, George Hal McIlroy, James J. Otis, E. J. Willke.

Miami County—William N. Adkins, Harold Carter, Paul E. Foy, John W. Gallagher, Robert L. Girouard, Jerry L. Hammon, George J. Hance, Berton M. Hogle, Kenneth F. Lowry, E. C. Puterbaugh, Roland A. Reich, Dale R. South, Jr., William W. Trostel, William W. Weis, Gerald F. Wolf, George A. Woodhouse, Ralph D. Yates.

Montgomery County—Arnold Allen, William R. Althoff, William M. Ankeney, Kenneth D. Arn, Roy D. Arn, Sterling H. Ashmun, Robert C. Austin, Raymond K. Bartholomew, Herman J. Bearzy, Norman J. Birkbeck, A. V. Black, David E. Brown, Jr., John R. Brown, Ian H. Brown, Robert A. Bruce, Arthur W. Carley, A. J. Carlson, Everett F. Conlogue, Robert M. Craig, E. F. Damstra, John M. Dasher, Charles A. Dille,

(Continued on Next Page)

Additional Scenes During the Banquet



Here are more of the groups including Councilors, Delegates, Committee Chairmen, and their ladies and guests.

R. Dean Dooley, Stuart R. Ducker, Stanley A. Earley, Jr.

Robert K. Finley, Jr., George H. Garrison, Richard J. Graves, Francis V. Grice, Carl H. Hall, William H. Hanning, Richard M. Haskins, Albert Hirsheimer, N. R. Hollister, Robert B. Jacobs, Mason S. Jones, Charles L. Kagay, Louis J. Kerth, Joseph S. Koehler, Richard S. Koehler, William S. Koller, Norbert L. Kosater, Howard Lauer, W.

J. Lewis, T. L. Light, Marion V. Lingle, Louis C. Loeber, William R. Love,

Frederic Maccabe, Jr., George I. Martin, James B. McMillan, Gerald E. Meyer, Jerome H. Meyer, Kenneth L. Meyers, Gordon B. Munson, Thomas E. Newell, George A. Nicoll, Charles E. O'Brien, Melvin Oosting, Leo E. Palmer, Neal C. Perkins, William M. Porter, Merrill D. Prugh, Jack M.

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(Members Who Attended Annual
Meeting—Cont'd.)

Randall, Samuel J. Randall, Erie F. Routley, Cecil F. Rust,

Richard T. Sauer, Harry B. Schiffer, Burt E. Schear, Benjamin Schuster, William L. Slagle, Norman F. Stambaugh, Harvey J. Staton, Paul R. Stauffer, W. V. Stinson, Albert M. Storrs, Edward R. Thomas, John F. Torrence, James G. Tye, Thomas A. Weaver, Jr., Jack W. Weiland, John D. Welsh, Kenneth A. Welty, Giles Wolverton, Robert E. Zipf.

Morgan County—Henry Bachman, Asia H. Whitacre.

Morrow County—William S. Deffinger, David J. Hickson, Joseph P. Ingmire, Francis W. Kubbs, William Lowell Murphy, Frank H. Sweeney.

Muskingum County—John Quincy Adams, Jr., Charles I. Cerny, Ward D. Coffman, Jr., Bela Danos, Walter B. Devine, Peter A. Fomenko, Harry T. Glaser, Joseph C. Greene, Earl R. Haynes, Robert S. Martin, James E. McCormick, Alfred C. Ormond, Flora M. Pedicord, George T. Thompson, Donald A. Urban, Charles L. A. Wehr, Earl B. Zurbrugg.

Noble County—Frederick M. Cox.

Ottawa County—William H. Dufendock, Patrick Hughes, James I. Rhie, Paul K. Ridenour, Cyrus R. Wood.

Paulding County—D. E. Farling, Kirkwood A. Pritchard.

Perry County—Alexander P. Demidov, Ralph E. Herendeen, Jr., Charles B. McDougal, Yu R. Yuan.

Pickaway County—Francis W. Anderson, Warren Russell Hoffman, Edward Lee Montgomery, Robert G. Smith.

Pike County—Robert M. Andre, Cecil L. Grumbles, Albert M. Shrader,

Portage County—L. R. Baumgartner, Robert E. Glasgow, Edgar M. Kauffman, Edward T. Meacham, Myron S. Owen, Robert E. Roy, Myron W. Thomas.

Preble County—C. J. Brian.

Putnam County—Donald B. Lucas, Joseph J. McHugh, Will W. Moody, Milo B. Rice.

Richland County—Alvin Bales, Russell H. Barnes, C. H. Bell, Rundle D. Campbell, Stanley L. Brody, Charles O. Butner, Charles F. Curtiss, Alexander M. Duff, Joseph B. Edelstein, Darrell B. Faust, Robert L. Garber, John S. Hattery, Vemont Dana Kerns, Wilson S. Kingsboro, Ernest B. Mainzer, Walter A. Massie, Gordon F. Morkel, Milton C. Oakes, Charles B. Phillips,

William R. Roasberry, P. O. Staker, Robert W. Tawse, Lawrence C. Thompson, Francis M. Wadsworth, Harry Wain, Hall S. Wiedemer, R. C. Wise.

Ross County—Edwin H. Artman, Jack C. Berno, Charles A. Clifton, Lewis W. Coppel, William J. Corzine, Jr., Harold M. Crumley, Ernest B. Cutlip, Theodore Cutright, John W. Franklin, L. T. Franklin, William M. Garrett, Robert P. Giesler, Nicholas H. Holmes, Ralph W. Holmes, Walter E. Kramer, Paul F. MacCarter, Jr., David McKell, Joseph S. McKell, Glen Nisley, F. Wayne Nusbaum, M. Dow Scholl, Byron Stinson, Robert E. Swank, Joseph Utrata, Adolf Wolff, G. Howard Wood.

Sandusky County—Charles L. Fox, Karl K. Grubaugh, William M. Hindman, Harold L. Keiser, Francis A. Visconti, Richard R. Wilson.

Scioto County—Lorenzo Dow Allard, Donald Appleton, Norton H. Bare, Albert L. Berndt, Walter A. Braunlin, William E. Daehler, Clyde W. Everett, Clyde M. Fitch, Joseph T. Gohmann, A. P. Hunt, Herbert M. Keil, Milton Levine, Ralph W. Lewis, Elizabeth B. Long, James P. McAfee, Thomas A. McMahon, Gilbert R. Micklethwaite, Spencer W. Miller, Julius V. Molnar, G. E. Neff, Carter L. Pitcher, Jerome M. Rini, William E. Scaggs, James F. Scott, William M. Singleton, Philip D. Weems.

Seneca County—Henry L. Abbott, Oswald G. Burkart, Jr., Robert C. Cahill, Walter A. Daniel, Thomas D. Efstation, William R. Funderburg, Maria Garlo, Olgierd C. Garlo, Lawton C. Gerlinger, E. Crede Hiestand, Edmund F. Ley, Donald J. Mariea, James L. Murphy, H. Robert Nie-mann.

Shelby County—R. W. Alvis, Richard H. Breece, H. Eugene Crimm, Robert I. Curry, Thomas W. Hunter, Boyd L. Mahuron, John P. Marsh, George J. Schroer, Edward P. Sparks, Jr.

Stark County—Marling L. Abel, James S. Adler, Edmund Beshara, William Bogedain, H. Howard Bowman, Alfons Cecys, Sylvester Thomas Centrone, Hammond P. Chen, William K. Cotton, Winfred M. Dowlin, H. W. Gauchat, Mark G. Herbst, Daniel A. Kibler, Maurice F. Lieber, Wayne L. McFadden, Alan N. Raftery, Ralph K. Ramsayer, Carlos D. Rian, William E. Sag, Paul C. Schwallie, John R. Seesholtz, John F. Thompson, R. E. Tschantz, John M. Van Dyke, John B. Walker, William A. White, Jr., Leo W. Zadinsky.

Summit County—Margaret R. Baker, Howard W. Bangs, Arthur A. Brown, Wendell T. Bucher, Paul A. Davis, Philip B. Demaine, Reynold P. Desman, Theodore V. Gerlinger, Frank R. Hanzel,

(Continued on Next Page)

Candid Camera Views During Banquet



The above camera scenes show a few more of the many Banquet table groups.

Walter A. Hoyt, Jr., Everett F. Hurteau, Donald I. Minnig, Edward F. Morris, John A. Moss, Byron E. Neiswander, George K. Parke, James W. Pond, Fred M. Rankin, Jr., John G. Repasky, David J. Roberts, George G. Stein, Donald M. Traul, James T. Villani, Edward L. Voke, Frank M. Warner, Rex H. Wilson, Ross R. Zeno.

Trumbull County—Edward E. Bauman, E. G. Caskey, Gene D. Fry, Frank T. Kandrak, Joseph W. Kohn, Marie B. Krupko, Paul E. Krupko,

Ralph E. Meacham, Robert J. Paul, Raymond H. Ralston, Densmore Thomas, Edwin R. Westbrook.

Tuscarawas County—Jurgis Balciunas, Chester A. Bennett, Jay W. Calhoon, Clark M. Dougherty, Philip T. Doughten, DeLoise H. Downey, M. W. Everhard, Paul D. Hahn, Joseph W. Hamilton, Eugene R. Hammersley, Robert B. Hines, Daniel D. Hostetler, William E. Hudson, Dale K. Lindberg, Donald W. Mastin, Edward L. Miller,

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(Members Who Attended Annual Meeting—Cont'd.)

Charles C. Newell, H. J. Reamy, Arthur J. Stevenson, Herbert F. Van Epps, Harold F. Wherley, George D. Woodward.

Union County—Walter R. Burt, Fred C. Callaway, Bernard E. Ingmire, E. J. Marsh, James M. Snider, Paul R. Zaugg.

Van Wert County—Edwin W. Burnes, Alford C. Diller, Joseph R. Kreischer, Harold C. Smith.

Vinton County—Herbert D. Chamberlain.

Warren County—Thomas E. Fox, O. Willard Hoffman, Orville L. Layman, David P. Ward.

Washington County—Clarence E. Ash, K. E. Bennett, Donald E. Fleming, George E. Huston, William R. Stewart, David D. Turner, Wilbur D. Turner.

Wayne County—Frank A. Cebul, Jr., Bernard M. Foster, Albert B. Huff, George J. Iten, J. Wylie McGaugh, J. T. Questel, Robert E. Reiheld, Richard W. Reiman.

Williams County—Paul G. Meckstroth.

Wood County—LeRoy J. Eulberg, Francis J. Nemcik, Paul F. Orr, Rupert A. Peatee, William H. Roberts.

Wyandot County—R. C. Garster, Allen F. Murphy, Franklin M. Smith, K. K. Solacoff, Walter B. Wozniak.

National Heart Program Scheduled in Philadelphia, October 23-25

Early registration is recommended for those planning to attend the 32nd annual scientific sessions of the American Heart Association to be held at the Trade and Convention Center in Philadelphia, October 23-25. Physicians who register by mail will receive a complimentary advance copy of the program booklet containing abstracts of the proceedings. This program will cost \$2.00 at the meeting. Forms for registering and for reserving accommodations are now available from the Association, 44 East 23rd Street, New York 10, N. Y.

This year for the first time the AHA's scientific session will include a joint program with the American College of Cardiology, which is holding its eighth interim meeting concurrently.

Another heart meeting is scheduled in November. The Council on Arteriosclerosis of the AHA will meet on Sunday and Monday, November 8-9 at the Hotel Knickerbocker in Chicago.

Parathyrin has proved effective as a protective agent against radiation, Drs. Raymond Rixon and James Whitfield of Canada's atomic energy center at Chalk River, Ont., report.

Ohio State Heart Association Elects Officers at Annual Meeting

Dr. Dale P. Osborn, Cincinnati, was named president-elect of the Ohio State Heart Association at the organization's Annual Meeting April 21 in Columbus. The scientific session of the heart

group was held in the Veterans Memorial Building while the non-medical meetings were in the Deshler Hilton Hotel.

Dr. John W. Martin, Cleveland, was installed as president at the meeting. Officers re-elected included the following: T. Stenson White, Cleveland, chairman of the Board of Trustees; Charles W. McCoy of Columbus, vice-chairman and



D. P. Osborn, M. D.

treasurer; and Mrs. Carl Strauss of Cincinnati, secretary.

Dr. R. W. Kissane, Columbus, was re-elected to the Executive Committee and representative director from Ohio to the American Heart Association.

Dr. Osborn is a past-president and member of the Council of the Cincinnati Academy of Medicine, a member of the Cincinnati Society, the Ohio Society, and the International Society of Internal Medicine, a Fellow of the American College of Physicians and American College of Cardiology.

Other proceedings included the announcement of the formation of a new Research Review committee of the Ohio State Heart Association headed by Dr. Simon Koletsky, of Western Reserve University, Cleveland.

The Committee was created for the purpose of approving worthy heart research projects and obtaining additional financial support for them from Heart Associations in areas where research facilities do not exist. A report from Dr. Koletsky stated that a number of Heart Associations in non-metropolitan areas had pooled their funds to support research projects in Ohio's major medical centers.

The Joint Council to Improve the Health Care of the Aged has named Howard I. Wells, Jr., Chicago, as its executive secretary. Offices of the new council were set up at 139 North Clark Street, Chicago. Mr. Wells has been serving as executive secretary of the American Association for Maternal and Infant Health since February 1954.

Dr. Mayfield's Address . . .

Remarks of Incoming President at Second Session of House of Delegates In Accepting the Official Gavel of the Association for the Year Ahead

By FRANK H. MAYFIELD, M. D., Cincinnati

GEORGE WOODHOUSE—gentleman, physician, loyal servant of the profession and dedicated citizen—it is with a hand that quavers that I accept from your firm one this historic gavel with its responsibilities.

It is a pleasure, however, as my first official act to speak the gratitude of this Association to you for your loyal and skilled service, and as a symbol of this gratitude to place in your lapel this gold pin which has been cast for you. You have, over the years, exemplified to me the best traditions of the practice of medicine, and also have been an outstanding example of the influence for good that the family physician can exercise in human relations beyond his immediate practice. You have distinguished yourself, brought honor to your profession and great good to mankind.

Expressions of Appreciation

It is also a pleasure to speak the appreciation of the Association to Robert Martin, whose duties as past-president ended when you handed me this gavel. Robert Martin, your colleagues in this society are grateful for your leadership and my affection and respect for you are profound. My wife, whose judgment in assessing human values I prize highly, stated to me last evening that she hoped that we might discharge the responsibilities that fall upon us this year with the wisdom and gentleness of Doctor and Mrs. Martin.

I would also express on behalf of the Association my appreciation to the retiring Councilors and offer my congratulations to Doctor Artman, the president-elect, and to the new Councilors and Delegates.

Two distinguished elder statesmen of medicine will this year complete their tours of duty as Delegates to the American Medical Association, and you would not wish me, as your president, to permit this occasion to pass without an expression of good wishes to Dr. Howard Schriver and Dr. Paul Davis for their long and skilled service in the House of Delegates of the A. M. A. We honor ourselves when we honor our elders, and to these gentlemen I say thank you and Godspeed.

Future Program

While I cannot hope to add to the impressive record of my predecessors in office I pledge to you,

the House of Delegates, my best efforts not to detract from that record. To the best of my ability I will implement the directives of this House and will represent you with as much dignity and skill as nature permits.

I would at this time ask your indulgence while I read a prepared statement in reference to the program that the Council will be asked to consider this year, for when to my surprise, you chose me to serve as your President this year, I began to look about for areas in which my experience and meager talents might be of greater service to our profession in order to justify the honor and responsibility which you have conferred upon me.

It seemed logical to look first to the organization of our administrative staff, and it will not surprise you to learn that after looking into this I have come up with no ideas whereby it might be improved. Also, at the outset, it seemed that our relations with certain state agencies left much to be desired. Somewhat to my surprise, I found that my predecessors in office and our own excellent staff, have anticipated me in this area by many years. This is, of course, a local where "eternal vigilance is imperative." We can never rest on accomplishments in our relationships with the changing moods of statecraft.

Must Be Alert

Much good can be achieved and much harm averted if we are always alert and ready to meet the issues that arrive at the point where public attitudes are brought into focus—where popular demands are converted into official action.

Our staff is more than meeting its primary obligations and responsibilities in this connection, though we as members may let them down at times when they alert us.

Challenging Opportunity

In the general field of public relations, however, there appears to lie a challenging opportunity. Not that I would regard myself as an expert in this complex area, but the system under which we work is under attack. We hear threats of socialized medicine because the cost of medical care is mounting. We hear criticism of medical

care of the aged. We hear accusations that doctors are going into specialized fields to escape the rigorous demands on the general practitioner.

Some uninformed and some malicious proponents of corrective measures under the guise of social progress constantly menace us. Most of us know the answers to these questions or at least we recognize the magnitude of the problem. But somehow we have failed in informing the public. We have failed, I think, because we have allowed our opponents to choose the weapons in this contest. Once when Abraham Lincoln was challenged to a duel by an expert marksman and swordsman, Lincoln accepted the duel but his choice of weapons was cow manure at 30 feet.

Must Meet the Challenge

We have been challenged and I feel we are entitled to choose the weapons in this duel. It will not be cow manure, as was Lincoln's, but the truth, for the truth is our strongest weapon. The truth of medicine is good—it is not perfect, to be sure—but it is good.

Until recently, the public concept of the profession as a whole was drawn for the most part from one's own physician. A man wise, and kind and selfless, dedicated to the care of the individual, regardless of his personal welfare; and with financial reward of secondary concern to him. Furthermore, he was generally regarded as invulnerable to the physical and mental stresses to which the rest of the humans are subject.

And now, even though the individual still likes his own doctor, the profession as a whole is often attacked, but the noble services from which the caricature of the American physician was drawn has not disappeared.

Two Illustrations

Recently I dropped in on Dr. W. Maurice Hoyt, whom most of us know. A man 77 years young and the father of one of our councilors, Dr. Hoyt at that time was recovering from a bad head injury. During this visit, he recounted to me his experience in the influenza epidemic of 1918, in which he had spent 18 to 20 hours a day making house calls, using a driver for his automobile in order that he might rest between calls. In many households he would find everyone in bed and oftentimes while he himself cleaned up the house and prepared the baby's milk for the mother who was sick, his driver would go to the wood pile, cut wood and renew the fires. This, in his opinion, was the medicine needed.

Later that day I stopped to consult with another physician in reference to a young man who in 1949 suffered a fracture of the spine which

resulted in paralysis of both legs and arms. The purpose of this consultation was to discuss rehabilitation of the patient. The patient was in excellent condition. His skin was good, his bladder clean. Not only had the doctor provided medical care for him for those 10 years without any charge, but he had often contributed money so the incapacitated youth might have some luxuries—and was leading a campaign for funds to transfer this patient to a rehabilitation center.

Balance Favors Medicine

Consider for a moment, if you will, the many homes run by religious orders for the care of aged, to whom physicians provide medical care without cost. Or note that in one issue of the daily paper of a large city of this state, recently two stories appeared, — one citing the gratitude of the editor of the paper for the care he had received at the hospital; another pointing out the kindness of the personnel in the hospital in providing a birthday party for an indigent who had been in the wards for a long time with burns.

Set these and the endless number of selfless, noble and skilled acts that occur in medicine every day in every community and every hospital in the land, along with the great adventures that occur every day in research, against the unfavorable aspects of our system and you will find the balance highly favorable to us.

Must Tell Story To Public

We must, of course, continue to search for and correct shortcomings and abuses in our system; and accept as constructive criticism inadequacies that are pointed out to us by others. But we must also acquaint the public with the true story.

In order to tell the story adequately, I think it is necessary to establish better relations between the local press and every county society in this state. My concept of the proper methods in this field are neither new nor original. Simply stated, its object is to get the people who make medical news to know and understand the people who write the news. I consider it appropriate and will ask the Council to authorize the use of this society as the instrument for bringing about a closer relationship between all the media of communications which I shall describe collectively as the press.

Specific Plan

I have in mind a specific program which has been utilized effectively at Cincinnati for 10 years. It is a simple formula, based on understanding and a mutual desire to achieve useful ends. The press in our area has accepted it, or

perhaps it might be more accurate to say the profession has accepted the proposal initiated by the press.

It is an arrangement that has been brought into being under the leadership of the late Dr. Husinkveld, when he became President of the Academy of Medicine of Cincinnati. I followed this foresighted leader into the Presidency of the Academy, just as today I am following him into the highest office of the state society.

This program, initiated in Cincinnati, has received wide acclaim in the press of the nation and with modifications is in force in many areas including the larger cities of this state.

The program as it has worked in Cincinnati is a simple one. It consisted basically of a resolution adopted by the local society to set up a committee to work on clearance and confirmation and indeed to help develop information for the press. That is about all there is to the mechanics. The real program is unwritten.

Once a year retiring and incoming officers of the Academy meet with representatives of the press. There is a convivial hour before dinner at which a friendly interchange on a first name basis is encouraged. This has served to break down formality and eliminate reservations. The dinner conversation has been undirected but usually flowed naturally into channels related to the subject.

The session which followed was a completely candid but informal one. Each side threw out specific instances from the previous year's experiences that had proven unsatisfactory. Each recognized its failings. These were explored with complete candor.

Results Good

Each year the number of deficiencies has decreased and more and more the conferences are able to point to examples of successful operation of press-medical relationship.

In the original concept of the Cincinnati plan, the subject was approached with certain basic elements clearly understood. The press made clear and the doctors agreed that the arrangement was not an acquiescence in any sense to a form of censorship stated or implied. The doctors made clear and the press agreed that this was in no way a compromise with the tenets of professional ethics. There was a clear understanding that the arrangement did not alter the historic relationship between the doctor and his patient, nor the basic concept of freedom of the press.

Learned About Reporters

We of the medical profession were quick to learn that the primary function of a good reporter

is the search for facts—the true facts—which the public is entitled to know. Certainly he is concerned with circulation of his paper or the audience for his broadcast, but we found that the good reporter, and most of them are good reporters, is convinced that reliable reporting is the best assurance of a good circulation; and the press came to learn, as we already knew, that good patient care is the best assurance of a good living.

The understanding has served effectively in removing artificial blockades to the publication of



Dr. Frank H. Mayfield, Incoming President, is here presenting his acceptance talk before the House of Delegates upon assuming the Presidency.

legitimate news related to medical subjects, ranging all the way from human interest stories of services over and above the call of duty to accidents and to medical research.

The press was surprised to learn that the basic reason for our restriction of the use of the doctor's name was the protection of the public from false advertising and not an internecine restraint of trade. The basic concept on the use of the doctor's name is that it not be used if the name is only incidental to the story, but definitely may be used when initiative resourcefulness or ingenuity on the part of the individual doctor is the basic element of the story.

P. R. Seminars

The Academy, of course, has not encouraged and would not permit advertising or efforts at

self-aggrandizement through publicity by individuals, but it has convinced its members that it is their duty to converse with the press and to permit them to use their names when they are requested to do so by the appropriate committee of the society.

My thoughts are that many of the societies may need help in promoting such programs and I envisage public relations seminars in each councilor district during the coming year. But by seminars I do not visualize a didactic program but instead use the word in its true sense, namely, that of a "seed plot" or a class of students engaged in original research or other specialized study.

Candid Discussions

It is my thought that the people who tell the news should be on this occasion the guests of those who make the news and join in a candid and friendly discussion of their objectives and differences.

If I am authorized to proceed, it is unlikely that a full schedule of meetings could be completed before the Fall, but when I accepted the responsibility of this office, I assured you that I would be at your service. I mean to abide by that promise. And if any district or county society wants to get going soon and would wish the help of the President, the Councilors or our administrative staff, or even perhaps outside professional help, we will be ready when you are.

Actually, this program would serve principally as a method of clearing roadblocks. Perhaps this was not needed 30 or 40 years ago, but today medicine and science are reaching into every facet of life; tongue twisting names of new drugs are used frequently by laymen. Specialized medicine is debated by people who have no connection with our profession except as patients who pay the bills. Hospital doors open to more and more citizens every day, largely because of progress of medical insurance. The public is intensely interested in medicine in many ways.

Observe that virtually every newspaper carries some kind of medical column in compliance with reader interest.

Benefit To All

We cannot, we should not, ignore these factors but rather we should take full advantage of the opportunity these conditions offer. I know if a closer relationship with the press is established, that immeasurable benefit will accrue to the public and hence, also to the profession.

The first step is to engender a new and friendly understanding with the media that confer with the public every day. I am convinced that they want

to tell the truth and the truth is good enough for me.

I also know from past experience that if they are unable to find the whole truth that they will tell what they believe to be the truth. It is incumbent upon us, therefore, to insure that they know the truth.

Once the lines of communication are open, the rest should be easy. We know if the public understands our ideals, recognizes the integrity of our standards, shares our intensity of purpose, we need have no fear for the future of the profession for which we have dedicated our lives. Ours is a great trust. We must preserve it inviolate.

WHAT TO WRITE FOR

Some booklets, pamphlets and other published material available for the asking or at nominal expense and suitable for the physician's office, library or waiting rooms, or for his personal information.

* * *

Disaster Research Group. Lists disaster study reports of Disaster Research Group, Division of Anthropology and Psychology, National Academy of Sciences. Covers various types of disasters. For list of reports available, write Publications Office, National Academy of Sciences - National Research Council, Washington 25, D. C.

AMA Policy on Medical Care of Veterans. Explains and discusses in detail current AMA policy on present veterans medical care program VA Department of Medicine and Surgery and related aspects. Write Council on Medical Service, AMA, 535 North Dearborn Street, Chicago 10, Illinois.

Practical Manual on Medical and Dental Use of X-Rays with Control of Radiation Hazards. Supplies basic, valuable information as compiled by American College of Radiology. 25 cents. Write American College of Radiology, 20 North Wacker Drive, Chicago 6, Illinois.

Enrollment in Voluntary Health Insurance in Rural Areas. Gives extent of farm family enrollment, compared with urban areas, and describes successful methods of increasing rural group enrollment. (15 cents) Write Superintendent of Documents, Government Printing Office, Washington 25, D. C.

Facts about Color Coding. Explains use of color coding of hospital materials, drugs, surgeon's gloves, bandages, etc., to increase safety and speed of handling. Write Becton, Dickinson and Company, Rutherford, New Jersey.

Auxiliary Report To OSMA . . .

Year's Activities and Accomplishments Are Reviewed Before Association's House of Delegates by Auxiliary President During the Columbus Meeting

By MRS. C. H. BELL, Mansfield

IT is indeed an honor to have the privilege of presenting the "second" annual report of the Woman's Auxiliary to this House of Delegates to the Ohio State Medical Association. The Auxiliary, as the name implies, aids the Medical Profession—carries on its activities under the directives and policies as prescribed by the Medical Association—through close cooperation with the advisory committee.

In this report, not all statistics will be given, but some are necessary to give a picture of auxiliary accomplishments.

Ohio Has 58 Auxiliaries

Ohio has 58 organized counties and with Members-at-Large in the unorganized counties gives us a membership of 5,081 members. We deeply regret the disbanding—two months ago—of Jackson County. Contact has been made with the Jackson County women to have them reconsider.

On the organizational map—a red dot is used indicating the county unorganized and without Members-at-Large. The disbanding of Jackson County gives us one red dot. Our goal is to have Ohio 100 per cent organized. Do you know Ohio is the fourth largest auxiliary in the National organization? And yet, we have not reached our potential.

Many Fields of Activity

Our program is a basic one—covering many fields of activities. It is not imperative the counties use the entire program. We ask the counties to tailor their program to their auxiliary and community needs.

This year emphasis has been placed on the four Priority Projects: The American Medical Education Foundation—Today's Health—Paramedical Careers Recruitment—and Safety.

AMEF Project

The Auxiliary has contributed to the A. M. E. F. since 1952. Ohio's goal this year is \$16,000.00. One-tenth the amount of National's goal. To date the Auxiliary has contributed \$15,100.00. We hope to reach and surpass our goal by the National

deadline—the last of May. However, many of the counties are over 100 per cent. This is evidence of our awareness of the importance of keeping the doors of our medical schools open.

Today's Health

In expanding the circulation of *Today's Health* magazine, we have urged a copy be in every physi-



Mrs. C. H. Bell is shown here presenting a report of Auxiliary activities for the past year before the House of Delegates.

cian's office, the home and numerable other places to increase Reception Room Readership to further authentic health information to the lay public. To date Ohio's subscription credits total 3555. This is a loss in credits of last year's figures at this time. Our credits are based on our membership. Assisting the Auxiliary in this project, Mr. Nelson so kindly prepared a coupon ad on *Today's Health* for publication in *The Ohio State Medical Journal* for your information and convenience.

Won Top Awards

In these two fields—Ohio won Top Awards at the National Convention in San Francisco last

June. Ohio was one of ten states receiving an A.M.E.F. award with the highest per capita contribution, but led all states *in* contributions. Our second award—*Today's Health*. We won over all other auxiliaries whose membership exceeded 3001 members. The state average on the National level for counties over 100 per cent was eight. Ohio had 25. We hope—by the end of April—to do this again.

Our aim is *not* based solely on winning awards, but competition *is* an incentive.

Nurse Recruitment

Of the 42 counties reporting by April 1—38 support the Nurse Recruitment program. There are 19 loan funds available. Seventeen auxiliaries offer a total of 46 scholarships and many counties give outright awards to deserving students. The loan funds and scholarships range in these counties from one to eight. Ohio has 67 Future Nurse Clubs and more are in the formation. Our aim is to interest these young people to enter a career upon graduation.

Careers Program

The film "Helping Hands for Julie" which was designed to attract students into careers has had at least 30 showings throughout the state. We are aware of the acute shortage of qualified persons to do the work that is so essential to continued progress in public health, and we are trying to help solve that problem.

In the field of Safety many counties reported having some type of safety program in way of—demonstrations—showing of safety films to auxiliary members and the lay public—displays—promoting a driver training course in the high schools and working with the safety council in their communities to alert people to the dangers in the home, on the farm and the highways.

Essay Contest

The 1958 House of Delegates again requested the Auxiliary to sponsor the Essay Contest of the Association of the American Physicians and Surgeons. This we have done. Three hundred essays were submitted for the contest. One county alone had 117 entries. The National judging will be in May and a report of the finals will be published. Several of the County Medical Societies or the Auxiliaries offer a cash prize to encourage participation in this project.

We have as an Auxiliary—proven and will continue to prove—as individuals and as citizens to be alerted to all legislation and act on these matters under the direction of our parent bodies

—the American Medical Association and the Ohio State Medical Association.

Other Activities

As suggested by the Civil Defense, Public Relations and Safety Chairmen the members have distributed over 200,000 Health Wallet Cards and over 80,000 Family Health Record Books. Another community service.

The activities of the Auxiliary are also carried out in the fields of Mental Health Geriatrics, GEMS (our baby sitting program) and all county organizations participate in many and varied civic projects.

The Newspapers—TV where possible, and series of radio—either live or by transcript are mediums used to bring to the lay public our program in promoting better health. No specific state program has been set-up for Television, Radio and Visual Education because of the variance in each individual community needs. However, the counties are doing outstanding work in this field.

Our pamphlet "Rx for County Auxiliaries"—a guide telling What - When - Who and How of auxiliary work (and which was made possible by your financial assistance) has gained National recognition.

The Auxiliary News

Since it is impossible to give you a report of the individual county's outstanding activities and accomplishments (for they are the State Auxiliary) I ask you to read our Auxiliary News. The News is published five times a year—and includes county projects and all annual reports. It is the medium for information of our Auxiliary work. Our activities are also published in *The Journal* of the Ohio State Medical Association. On the state level, among many of our duties and responsibilities of guiding the county auxiliaries, we plan and prepare a Fall Conference which is a workshop type meeting for all officers and chairmen.

Expresses Appreciation

And now, I have saved the best until last. The Auxiliary has always had the finest of counseling and advice—given willingly by our Advisors and the Ohio State Medical Office. For this we have been grateful, but our gratefulness and deep appreciation is for *your* providing an annual appropriation to the Auxiliary. On behalf of the Board of Directors and all members of the State Auxiliary, I wish to extend their thanks for this financial assistance which has made possible: (1) The publication of "Rx," (2) Secretarial assistance to the organization, (3) And on action of the Board of Directors at our Pre-Convention Board

meeting this afternoon part of this financial support was allocated to the cost of publishing our *Auxiliary News*, for state committee expenses and printing of our convention program. It is and has been for many years our wish to have our *News*—self supporting, without selling advertising.

A detailed record of the expenditures of this fund is kept on file. An interim report was made to The Council. A yearly report and interim re-

port will be given The Council for your information.

"Thanks" is not sufficient, but the Auxiliary objectives in "action" will prove the fund is and will be used to the best advantage.

This, then is our Best—endeavoring to accomplish our objectives in all accepted programs and function as a working organization in cooperation with the Medical Society.

Woman's Auxiliary Annual Meeting . . .

Doctors' Wives Have Busy Time in Columbus Summing Up Activities And Laying Plans for the Year Ahead; Officers and Committees Named

A PRE-CONVENTION BOARD meeting began the women's activities early Monday afternoon, April 20. An opening day tea for all members then followed in the Victorian Room. The Board meeting reconvened after a dinner and when Mrs. C. H. Bell, president, returned from giving her report of the year's activities to the House of Delegates of the Ohio State Medical Association. (See pages 867-870.)

Official business sessions began Tuesday morning, April 21, with Mrs. Bell presiding. The Rev. Ralph E. Henard, of the Bexley Methodist Church, gave the invocation. After the pledge of allegiance to the flag and the pledge of loyalty to the Auxiliary, greetings were extended to the group by Dr. James L. Henry, president of the Columbus Academy of Medicine, Mrs. George O. Kress, president of the Woman's Auxiliary to the Columbus Academy of Medicine and Mrs. Harry Wain, president of the Woman's Auxiliary to the Richland Academy of Medicine.

After several reports and the President's address, a luncheon was held honoring Mrs. Frank Gastineau, president-elect of the Woman's Auxiliary to the American Medical Association, past-presidents, honorary members of the Woman's Auxiliary to the Ohio State Medical Association, out of state guests, who were: Mrs. Herbert C. McClelland and Mrs. Harry W. Buzzard, president and president-elect of the Pennsylvania Auxiliary, Mrs. Robert R. Pittman, president-elect of West Virginia Auxiliary, and Mrs. Harold Gay, president-elect and Mrs. Clarence Owen, vice-president of the Michigan Auxiliary, board members and county presidents. Montaldo's of Columbus presented a beautiful fashion show to everyone's delight.

The second business session began in the after-

noon when Mrs. William H. Evans of Mahoning County conducted an "In Memoriam" service assisted by Mrs. John Dickie of Lucas County.

A program titled "Let's Map It Out" with Mrs. Myron Thomas, second vice-president, Portage County, as moderator, presented reports by the chairmen of American Medical Education Foundation, Safety, Civilian Defense, Bulletin, Auxiliary News, Television and Radio, and Credits and Awards.

The annual Gavel Club dinner was held that evening.

Wednesday Program

Wednesday morning session included reports of the Resolutions and of the Revisions and Finance Committees. Presentation was also made of the counties receiving American Medical Education Foundation awards.

The annual Doctors' Day luncheon followed in the Grand Ball Room of the Deshler-Hilton Hotel at which the following were honored: Dr. George A. Woodhouse, President of the Ohio State Medical Association, Dr. Frank H. Mayfield, OSMA President-Elect, Dr. C. L. Pitcher, chairman, Dr. H. T. Pease, Dr. C. A. Gustafson, Advisory Committee, Dr. James L. Henry, president Columbus Academy of Medicine, Dr. Merrill S. Prugh, American Medical Education Foundation chairman, OSMA, Dr. John S. Hattery, Dr. and Mrs. C. H. Bell, Dr. and Mrs. C. A. Colombi and all Ohio doctors.

A special meeting of delegates was called by the president for a session following the luncheon for the purpose of discussing revisions which are subject to the Council's approval. Because of the participation of many of the delegates in this matter as they reviewed the bylaws by article, the program "Liaison—the Golden Thread" to be

moderated by Mrs. C. A. Colombi, president-elect, had to be postponed.

Thursday Program

The fifth business session began Thursday morning with the presentation of achievement awards. Mrs. Frank Gastineau, president-elect of the Woman's Auxiliary to the American Medical Association, gave an inspiring address after which she installed the new officers. Mrs. Bell presented the gavel and presidents' pin to Mrs. C. A. Colombi, the new president, and Mrs. A. Paul Hancuff, a past-president, presented the past-presidents' pin to Mrs. Bell.

The inaugural address given by Mrs. Colombi expressed:

1. Tribute to her predecessors.
2. Policy as defined by auxiliary advisors (doctors chosen by county and state medical societies).
3. Program to interpret the policy—such as projects in American Medical Education Foundation, Care of the Aged, Legislation, Community Service, Paramedical Careers, Safety, Civil Defense and Mental Health.
4. Promotion of Program—"No more satisfying, challenging and stimulating avenues for the energies of a doctor's wife than to serve her husband and his profession, as a trained, active Auxiliary worker."

Appreciation for planning and the hospitality in Columbus was expressed to the Convention Chairmen, Mrs. Homer Anderson and Mrs. Edward Turner, after which the Nineteenth Annual Convention of the Woman's Auxiliary to the Ohio State Medical Association was adjourned.

Post-Convention Board Meeting

Mrs. Colombi presided at the Post-Convention Board meeting where officers and committee chairmen stated objectives for the year 1959-1960. The following announcements were made:

Fall Conference, Lincoln Lodge, Columbus, September 15 and 16.

Mid-Winter Board Meeting, Deshler-Hilton Hotel, Columbus, January 20.

1960 Convention, Cleveland, May 16 to 20.

Because a study of Care of the Aged is prominent as a project by American Medical Association, the president asked Board approval to establish this special chairmanship on the State Board level. This request was granted unanimously.

Officers, Directors and Committees

A roster of new Auxiliary officers is printed on page 750 of this issue.

District Directors: 1st—Mrs. Earl Van Horn,

Cincinnati; 2nd—Mrs. R. D. Hendrickson, Xenia; 3rd—Mrs. Charles Blumstein, Lima; 4th—Mrs. C. J. A. Paule, Toledo; 5th—Mrs. J. B. Hazard, Cleveland; 6th—Mrs. Edward Bauman, Warren; 7th—Mrs. Floyd Craig, Coshocton; 8th—Mrs. J. R. Wells, Newark; 9th—Mrs. Wm. Singleton, Portsmouth; 10th—Mrs. Rivington Fisher, Columbus; 11th—Mrs. F. M. Wadsworth, Mansfield.

Standing Committee Chairmen and Directors-at-Large are: Historian Archives—Mrs. W. H. Evans, Youngstown; Legislation—Mrs. C. F. Goll, Steubenville; Program—Mrs. A. L. Kefauver, Columbus; Community Service—Mrs. Morton Block, Dayton; Publicity—Mrs. Wm. J. Horger, East Liverpool; To-Day's Health, Bulletin—Mrs. James Wychgel, Cleveland.

Special Committee Chairmen: American Medical Education Foundation—Mrs. Reuben Pliskin, Akron; Civil Defense—Mrs. F. Visconti, Fremont; Convention Chairman—Mrs. Eugene Gessler, Cleveland; Convention Co-Chairman—Mrs. Fred Rittinger, Cleveland; Credits & Awards—Mrs. Herbert Van Epps, Dover; Fall Conference Chairman—Mrs. Charles Pavey, Columbus; Fall Conference Co-Chairman—Mrs. Robert Heilman, Columbus; Members-at-Large — Mrs. Harvey Staton, Dayton; Mental Health—Mrs. Philip Doughten, New Philadelphia; Nominating—Mrs. C. H. Bell, Mansfield; Paramedical Careers—Mrs. Mary Deeter, Troy; Parliamentarian—Mrs. Paul Woodward, Cincinnati; Reference & Revisions—Mrs. Karl F. Ritter, Lima; Safety—Mrs. R. F. Kelly, Xenia; Television, Radio & Visual Education—Mrs. Earl Young, Youngstown; Auxiliary News Editor—Mrs. N. M. Reiff, Washington Court House; Circulation Mgr.—Mrs. J. Martin Byers, Greenfield; Advertising Mgr.—Mrs. Boni Petcoff, Toledo.

National Convention: In addition to Mrs. C. A. Colombi who will be presidential delegate, 16 delegates were elected to attend the convention of the Woman's Auxiliary to the American Medical Association in Atlantic City, June 8 to 12. They are: Mrs. C. H. Bell, Mansfield (chairman of Delegates); Mrs. Morton Block, Dayton; Mrs. Roswell Fidler, Columbus; Mrs. K. J. Fleish, Newark; Mrs. V. R. Frederick, Urbana; Mrs. C. F. Goll, Steubenville; Mrs. A. Paul Hancuff, Toledo; Mrs. George T. Harding III, Columbus; Mrs. J. B. Hazard, Cleveland; Mrs. Carl Mader, Cuyahoga Falls; Mrs. Crawford McLain, Dayton; Mrs. George Petznick, Cleveland; Mrs. Lester Sontag, Yellow Springs; Mrs. Fred Rittinger, Cleveland; Mrs. Myron Thomas, Garrettsville; Mrs. Herbert Warm, Hamilton.

UNIQUE VITAMIN SUPPLEMENT

NEW **VIGRAN**

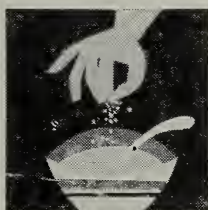
CHEWABLES

SQUIBB MULTIPLE VITAMIN SOFT TABLETS

fruit-punch flavored
tablets that will
actually
"melt in the mouth"



can be chewed like candy



can be crushed and sprinkled on
cereal or other food



can be dissolved in water, juice or milk



can be sucked and will dissolve like a lozenge



can be easily swallowed (small tablet size)

VIGRAN CHEWABLES *taste like candy*, but contain *no ingredients harmful to teeth*. Important, too, is that VIGRAN CHEWABLES *dissolve easily* in the mouth and *smell good*. These advantages will also appeal to your elderly patients. And VIGRAN CHEWABLES provide at least 125% of the minimum daily requirements for vitamins A, D, B₁, B₂, niacinamide and C, and significant amounts of other essential vitamins.

Each VIGRAN CHEWABLE tablet contains:

Vitamin A	5,000 U.S.P. units
Vitamin D	1,000 U.S.P. units
Vitamin C.....	75 mg.
Vitamin B ₁	3 mg.
Vitamin B ₂	3 mg.
Vitamin B ₆	2 mg.
Niacinamide	25 mg.
Calcium Pantothenate.....	3 mg.
Vitamin B ₁₂	5 mcg.

Available in Rx-size bottles of 30 and 90.

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*Squibb Quality—
the Priceless Ingredient*

^{*}Vigran[®] is a Squibb trademark

From the Drug Lab to the Patient . . .

Rigid Discipline Dogs Every Step of a New Drug from Its Start in the Laboratory Until It Reaches Its Destiny in the Hands of the Patient

WHEN a laboratory develops a new drug, accurate methods of identification and testing must be devised. Specifications must be set, as well as means of determining that every batch of the drug that is prepared will fall within these specifications.

Most manufacturers, no matter what they produce, realize that long term success rests ultimately with the maintenance or improvement of product quality. To the pharmaceutical industry, however, quality control transcends this. When a physician prescribes a pharmaceutical preparation, he must be able to anticipate the response which his patient should get from its administration. In order for this to be possible, every lot of the preparation must be uniform. It is toward this end that the quality control laboratory works.

The purity of all the materials that go into a pharmaceutical preparation, and the accuracy of the quantities added, are the obvious elements of quality control. But there are others, too: stability, for example, as it refers to the maintenance of stated potency over a period of months or years; disintegration time of compressed tablets and dissolution time of coated tablets; sterility of injectables and ophthalmic preparations; viscosity and surface tension of liquids; melting point; and uniformity of taste, smell, appearance and texture.

The analytical side of control work is exacting, for it involves quantitative and qualitative analysis of complex chemical mixtures. A multiple vitamin formula containing ten ingredients is an example. It is not a simple matter to mix the ten vitamins together. But when they are mixed, ingenious analytical methods are required to determine from the finished product that all ten ingredients are present in their correct amounts and that an eleventh has not slipped in unnoticed or by substitution.

Many of the ingredients involved in such mixtures are present in exceedingly small quantities. A drop of water weighing 50 milligrams is 1,000 times heavier than the dose of 50 micrograms of vitamin B₁₂ which may be present in a multiple vitamin formula.

In the ceaseless search for faster, more accurate means of quality control, new techniques and instruments are being constantly devised. Fluoro-

EDITORIAL NOTE:

With thousands of drug preparations on the market, competition in the field is keen. Yet the ethical pharmaceutical house must maintain the strictest discipline in the manufacture and distribution of its products. Comprehensive quality safeguards and testing procedures account for as much as 15 per cent of the drug's cost.

In other words, safeguarding the patient plays an important part in the cost of new drugs and old. A few words on this point from the doctor may do wonders to lift the patient's morale, especially if he is burdened by "the high cost of medical services."

The accompanying article is presented in lay terms deliberately so the doctor can pass on information to the patient in his own terms. It is excerpted from a pamphlet entitled *Facts About Pharmacy and Pharmaceuticals*, published by the Health News Institute. This is the final article in a series which began in the January issue.

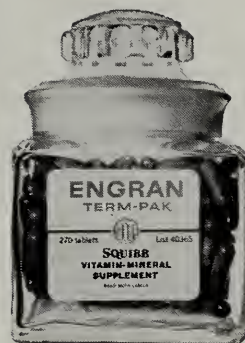
photometers, spectrophotometers, automatic titrimeters—these are among the newer laboratory tools. Polarizing microscopes equipped to measure optical constants indicate melting points. Paper chromatography and gas chromatography have their uses. Radioactive isotopes help assay preparations containing rauwolfia compounds. Bacterial cultures assist in measuring the activity of antibiotics as well as the potency of vitamins.

Quality control does not stop when the products are shipped from the manufacturer. Periodic tests are run to make certain that products have not changed over a period of time under actual storage conditions.

Elaborate precautions must be taken in the preparation of injectable solutions to make certain that they are not contaminated with microorganisms or their products. Tests are run routinely by the control laboratory to make certain that solutions are sterile. Additional studies are carried out with animals to see that fever-producing substances (pyrogens) are not present.

Quality control procedures must be defined

Just one prescription for
Engran "Term-Pak"
SQUIBB VITAMIN-MINERAL SUPPLEMENT



calling for one tablet a day will carry her through term to the six-week postpartum checkup. This means you are assured of a nutritionally perfect pregnancy, and she realizes major savings.*

SQUIBB



Squibb Quality — the Priceless Ingredient

'ENGRAN'®, 'TERM-PAK' and 'FLEXIDOSE' ARE SQUIBB TRADEMARKS



* *And when baby comes, specify Engran baby drops — full vitamin support in half the volume of most similar preparations — lasts twice as long. Supplied in 15 cc. and 50 cc. bottles. Convenient 'Flexidose' Dropper assures accurate dosage.*

when the company files a new drug application with the Food and Drug Administration.

According to some manufacturers, these tireless, painstaking, comprehensive quality safeguards and testing procedures are responsible for from 10 to 15 per cent of the production costs. Yet, like the air we breathe, quality control is readily apparent if it is lacking.

New Drug Application

In accordance with the Food, Drug, and Cosmetic Act of 1938, a new drug cannot be marketed legally unless the manufacturer has an effective new drug application for it on file with the Food and Drug Administration in Washington, D. C. The application is prepared and submitted by the manufacturer. The Food and Drug Administration does not approve the application, but permits it to become effective. Such an application is required to contain:

1. Full reports of investigations which determine that the drug is safe for use in the dosage recommended.
2. A full list of the materials used as components of the drug.
3. A full statement of the composition of the drug.
4. A full description of the methods used in, and the facilities and controls for, the manufacture, processing, and packing of the drug.
5. Such samples of the drug and of the articles used as components as may be required.
6. Specimens of the proposed labeling and promotional material.

The criterion for acceptance of an application for a new drug is safety, based on usage, as directed in the labeling, and not therapeutic claims for the drug's efficacy. Of course, safety and efficacy cannot be completely divorced from each other; for example, a relatively toxic drug may be released for use in a serious disease on the basis that its usefulness outweighs its potentiality for harm.

The Act places a serious responsibility upon the Food and Drug Administration, for no valuable drugs should be unnecessarily withheld from public use. But the primary responsibility remains with the manufacturer.

What Is a "New" Drug?

Simply stated, a drug is "new" if qualified experts do not recognize it as safe when used as directed. A new drug remains "new" for a new manufacturer, even though other manufacturers have provided adequate evidence of safety. Each manufacturer must provide adequate evidence for

his own product before he can legally market a new drug.

Food and Drug regulations point out that a product may be considered "new" not only when it contains a new active ingredient but also when it includes a new excipient, coating, solvent, carrier, or other component.

A new combination of two or more old drugs, or a change in the usual proportions of the ingredients in an old combination, may cause the product to be considered a new drug if a question of its safety is introduced. A new use, a new dosage schedule, or a new route of administration for a commonly recognized drug may also result in a new drug within the meaning of the definition.

Actually, about 90 per cent of the new drugs which became available in the first ten years under the Act were "new" only through or according to the definition given in the statute. They did not represent a genuinely new addition to drug therapy and were either duplications of types of products already available, minor modifications or combinations, or new dosage forms. They may be taken as a prime example of the continuing efforts of pharmaceutical manufacturers to make the newest materials available, or to improve their current items.

Evaluation of the manufacturer's evidence of safety often does not end with the initial marketing of the drug. Up to this time the preparation has been produced in small quantities, and restricted to the use of investigators qualified to perform the scientific testing necessary to establish its safety.

If it is widely accepted by the medical profession, a whole series of supplemental applications may be submitted as a result of expansion and improvement of manufacturing facilities and experience in widespread use which may require labeling changes. For example, 2,277 supplemental applications went into effect in the fiscal year ending June 1955. Of these 1,163 were for veterinary preparations. In 1956 some 2,492 supplemental applications went into effect, of which 1,248 were for veterinary preparations.

Most of the applications which have not become effective since 1938 were incomplete, or were withdrawn, or were for products which were not legally new drugs under the statute.

Names and Trademarks

A drug is usually identified with no less than three names; a chemical name which describes it; a common, or non-proprietary name; and a brand name—a registered trademark which belongs to

the first ^{*oral*} antifungal
antibiotic for ringworm

fulvicin*

griseofulvin

Schering

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soon available

the company marketing the drug. There is a definite rationale in having three designations.

1. The chemical name describes the substance to a chemist. It is a technical term and is prepared from a set of rules for describing chemical compounds. This chemical name, however, is usually too unwieldy for everyday use.

2. The non-proprietary name is the common name for the drug. From the standpoint of public health, the most important function of the non-proprietary name is to provide a name common to all producers of the drug, both in the United States and abroad, for purposes of identification and further, to designate the drug in the literature for non-commercial purposes, especially in science and teaching publications.

3. The trademark not only identifies the drug but also identifies it as the product of a single manufacturer. This brand name is important to the manufacturer in building a market, for as time goes on, the trademark becomes associated in the minds of the medical profession and the public generally with the manufacturer. The prescriber or purchaser will judge the product first hand in the light of the established good will and reputation of its maker, his methods of doing business, and his ability to market products which meet standards of purity and potency.

The trademark is equally valuable to the physician and the patient. The physician can specify the particular brand of a product for which he has a preference and which he feels is best suited to his patient's need. The patient, for his part, knows that he will obtain exactly the product that his physician intended for him no matter where he takes his prescription to be filled.

This availability of a range of alternatives from which the prescribing physician or pharmacy customer can choose is a sign of a healthy and vigorous industry. It encourages competition among manufacturers and provides the purchaser with a better product for less money.

National Physicians and Schools Conference Is Oct. 13-15

The AMA Bureau of Health Education has announced that the seventh National Conference on Physicians and Schools will be held Oct. 13-15 at Morain-on-the-Lake Hotel, Highland Park, Ill.

The bureau sponsors the biennial conference, which is open to representatives of state and territorial medical societies, health and education departments. More than 200 persons are expected to attend.

Do You Know? . . .

Dr. Herbert W. Salter, Cleveland, was named a member of the Board of Trustees of the American Academy of General Practice at that organization's annual meeting in San Francisco.

* * *

Among 14 national winners in the essay contest sponsored by the Association of American Physicians and Surgeons was one from Ohio. Dorothy Stafford of Howard, won \$75 for her essay entitled "The Advantages of the American Free Enterprise System."

* * *

Dr. Roy T. Lester, medical director of Blue Cross-Blue Shield of Texas for the last five years, has been appointed manager of the AMA Washington Office.

* * *

A new publication, *Ohio Law Enforcement Training Bulletin*, is being published bi-monthly by the Western Reserve University Law-Medicine Center. The editorial staff includes Oliver C. Schroeder, Jr., director of the center; Dr. Samuel R. Gerber, Cuyahoga County coroner, and George W. O'Connor, instructor in Criminology at Western Reserve.

* * *

Dr. F. W. McNamara, Youngstown, was honored recently by the Irish-American Civic and Cultural Association at the organization's annual dinner.

* * *

Dr. George A. Woodhouse, Immediate Past-President of the Association, was elected to receive the Ohio University Alumni Association's highest award, the Certificate of Merit for distinguished achievement in his profession. An alumnus of the university, he is scheduled to receive the presentation at a luncheon on the Athens campus on June 6.

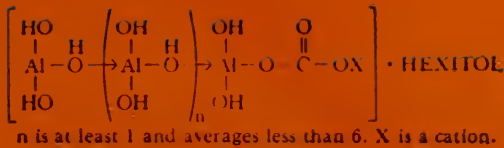
* * *

Dr. James Payson Dixon, Jr., since 1952 health commissioner for Philadelphia, and professor of public health at the University of Philadelphia, has been named president of Antioch College, effective July 1. A 1939 graduate of Antioch, he received his M. D. degree from Harvard.

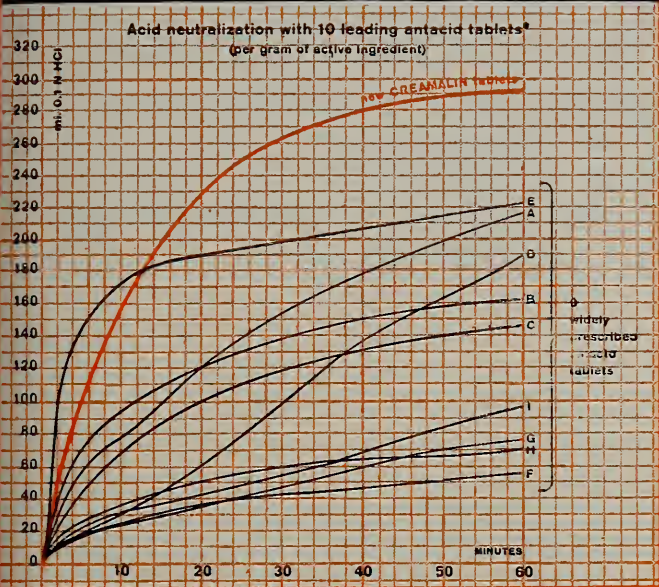
* * *

Dr. Edward A. Gall, professor of pathology at the University of Cincinnati College of Medicine, has been appointed a member of the National Board of Medical Examiners and chairman for a four-year term of the board's pathology test committee. He has been member of the committee for several years.

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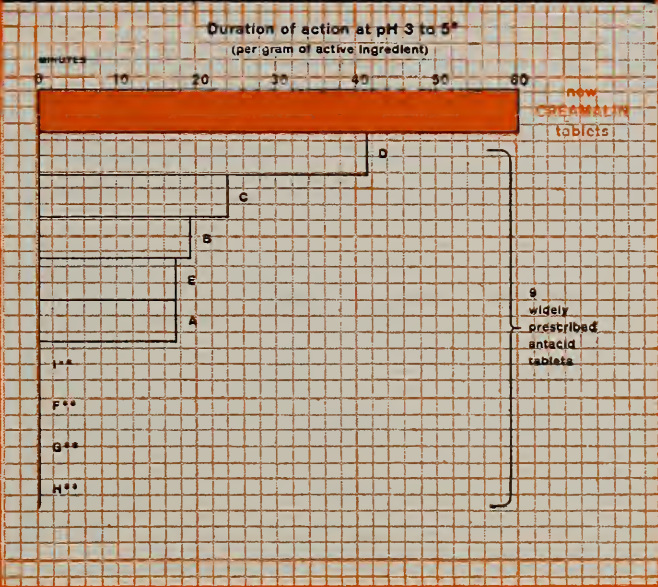


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More Lasting Relief



*Minkel, E. T., Jr., Fisher, M. P., and Talbot, M. L.: A new highly reactive aluminum hydroxide complex for gastric hyperacidity. To be published.
**ph stayed below 5.



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In Memoriam . . .

James G. Alcorn, M.D., Columbus; Miami Medical College, Cincinnati, 1902; aged 76; died April 29; member of the Ohio State Medical Association and the American Medical Association. Dr. Alcorn practiced for many years in Columbus where he specialized in eye, ear, nose and throat work. He was a recipient of the OSMA 50-Year Award. Surviving are his widow and a brother.

Laurence E. Anderson, M.D., Greentown; Ohio State University College of Medicine, 1929; aged 57; died April 26; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. A practicing physician in Greentown since 1933, Dr. Anderson was active in medical organization work and in affairs of the community. He was a past-president and former secretary-treasurer of the Stark County Medical Society; also active on a number of committees of the local Society. He formerly served on the Rural Health Committee of the State Association. Affiliations included memberships in several Masonic bodies, the Methodist Church, the Elks Lodge and other community groups. Surviving are his widow, a son, a daughter, a brother and two sisters.

Charles R. Colburn, M.D., San Bernardino, California; Eclectic Medical College, Cincinnati, 1927; aged 64; died April 12; former member of the Ohio State Medical Association. Dr. Colburn had been living in California for about two and a half years. He was a former resident of Fairborn in Greene County, and a number of years ago was health commissioner for Clermont County and practiced in that area. A member of the Masonic Lodge, he is survived by his widow, a son, three daughters and a sister.

Louie Cooper Cosgrove, Sr., M.D., Swanton; Toledo Medical College, 1901; aged 79; died April 21; member of the Ohio State Medical Association and the American Medical Association. A native of Swanton where his father also practiced medicine, Dr. Cosgrove served that community as a doctor for 54 years before his retirement four years ago. He was active in numerous local organizations and community affairs; was a member of several Masonic bodies, the Forresters, Modern Woodmen, Knights of Pythias, and the American Legion, being a veteran of World War I. Surviving are his widow and a son, Dr. L. C. Congrove, Jr., also of Swanton.

James P. Cozzens, M.D., Cleveland; St. Louis University School of Medicine, 1924; aged 61;

died May 2; member of the Ohio State Medical Association and the American Medical Association. A practicing physician in Cleveland for many years, Dr. Cozzens for the past five years was head of the health service for the Cleveland Public Schools. He previously held a similar position on a part-time basis. Surviving are his widow, a son, two brothers and three sisters.


Harry F. Deubel, M.D., Hamilton; University of Cincinnati College of Medicine, 1927; aged 61; died April 8; member of the Ohio State Medical Association and the American Medical Association. A resident of Hamilton since early in his life, Dr. Deubel served all of his professional career there. He served a period as Butler County coroner and in 1942 was appointed county physician. A member of the Catholic Church and the Knights of Columbus, he is survived by his widow, a daughter and his father.

Joseph Harlan Frame, M.D., Wilmington; Ohio State University College of Medicine, 1909; aged 77; died April 13; member of the Ohio State Medical Association and the American Medical Association. A native of Muskingum County, Dr. Frame began his practice there and moved to Highland where he practiced for about 30 years. He had been in Wilmington since 1943. Affiliations included memberships in several Masonic bodies. Surviving are his widow, and his son-in-law and daughter, Dr. and Mrs. H. Richard Bath, of Wilmington.

John Golowin, M.D., Gettysburg, Darke County; aged 71; died April 9. A native of the Ukraine, Dr. Golowin practiced there and in Neurenberg for 41 years before he came to this country. Two sons survive.

John A. Gosling, M.D., Tiffin; Rush Medical College, 1901; aged 85; died May 8; member of the Ohio State Medical Association and the American Medical Association. Dr. Gosling practiced medicine for a total of 56 years, approximately 50 of those years in the Tiffin vicinity. For many years also he was local health commissioner. A veteran of World War I, he was a member of the American Legion. Surviving are his widow and two daughters.

John A. Rombkowski, M.D., Toledo; Stritch School of Medicine of Loyola University, 1918; aged 74; died April 14; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Rombkowski was a lifelong resident



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of Toledo and practiced medicine there since the completion of his medical training. He was a member of the Catholic Church and the Holy Name Society. Surviving are a sister and a brother.

A. Ashley Rousuck, M. D., Cleveland; Wayne State University College of Medicine, 1939; aged 48; died April 22; member of the Ohio State Medical Association and the American Medical Association. Dr. Rousuck had been in practice in Cleveland for a number of years. He is survived by his widow, a daughter, two brothers and four sisters.

Wallace W. Ryall, M. D., Youngstown; University of Pittsburgh School of Medicine, 1897; aged 84; died April 25; member of the Ohio State Medical Association and the American Medical Association; past-president of the Mahoning County Medical Society. Dr. Ryall practiced medicine for more than a half century before his retirement in 1954. In that year he was honored by a number of groups for his service to the community. For 14 years he was a member of the local board of health, was a past-president of the Kiwanis Club and active in other organizations. Surviving are a daughter, two sons, a brother and a sister.

Alfred Sandor, M. D., Cleveland; medical degree from the University of Budapest; aged 80; died May 3. A former practicing physician in Europe, Dr. Sandor lived for 40 years in Cleveland where he formerly was in the real estate business. He is survived by his widow, two sons and two daughters.

Clarence B-P. Slaughter, M. D., Cleveland; University of Toronto Faculty of Medicine, 1923; aged 58; died April 24; member of the Ohio State Medical Association and the American Medical Association. Dr. Slaughter moved to Cleveland in 1932 and became an associate in the Collinwood Clinic. A native of Canada, he served

with the British Army during World War I and attained the rank of major. Before going to Cleveland he took residency work in New York and for a time was on the faculty of the University of Michigan School of Medicine. Survivors include his widow and a daughter.

Clifford A. Smith, M. D., Clarington; Baltimore Medical College, 1909; aged 82; died April 9. Dr. Smith practiced from 1909 to 1921 in Wetzel County, W. Va., and in the latter year moved to Clarington where he continued in practice to the time of his death. Surviving are his widow, three sons and two sisters.

J. Russell Smith, Jr., M. D., Middleburg Heights and Cleveland; Western Reserve University School of Medicine, 1951; aged 34; died April 20; recent member of the Ohio State Medical Association and the American Medical Association. A veteran of World War II, during which he served with the Air Force, Dr. Smith was engaged in the practice of surgery after completing residency training at Western Reserve. He is survived by his widow, three sons and his parents.

Paul M. Spurney, M. D., Cleveland; Western Reserve University School of Medicine, 1917; aged 66; died April 25; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Spurney had been a practicing physician since the completion of his medical training in the Cleveland area, where his father, the late Dr. Albert F. Spurney, also practiced. Dr. Paul Spurney was also for 29 years health director for Shaker Heights. A veteran of World War I, during which he served with the Army Medical Corps, he held memberships in several professional and civic organizations, including the Rotary Club. His widow, two sons and two sisters survive.



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Activities of County Societies . . .

First District

(COUNCILOR: CHARLES W. HOYT, M. D.,
CINCINNATI)

ADAMS

The Adams County Medical Society met on April 16 for a pre-luncheon meeting in the office of the Adams County Department of Health. Dr. Ben Friedman was speaker for the occasion and discussed "Radioactive Isotopes." Luncheon followed in the hospital dining room.

BUTLER

A panel discussion on the subject "Prepaid Medical Care Programs," was held at a meeting of the Butler County Medical Society. Participating in the discussion were: Dr. Asa Barnes, area medical administrator of the United Mine Workers of America, Welfare and Retirement Fund, Louisville, Ky.; Dr. Clyde Chamberlin, president, Butler County Medical Society; Maynard D. Conklin, treasurer, Champion Paper and Fibre Co., moderator; Brooks Billman, director of Industrial Relations, Armco Steel Corp., Middletown; and Dr. R. Dean Dooley, director of physicians relations of the Ohio Medical Indemnity, Columbus.

HAMILTON

A symposium on "Steroid Therapy and Its Newer Concepts," was the program feature for the April 7 meeting of the Academy of Medicine of Cincinnati. Guest speakers were Dr. Elmer Alpert, instructor in medicine, College of Physicians and Surgeons and director of clinical research for the Merck Sharp & Dohme Research Laboratories; and Dr. L. Maxwell Lockie, professor and head of the Department of Therapeutics, University of Buffalo School of Medicine.

A traffic safety exhibit sponsored by the Academy and open to the public on May 2 and 3 is reported elsewhere in this issue.

WARREN

The Warren County Medical Society met on April 14 with Dr. M. D. Sheldon, Cincinnati, as guest speaker. His topic was "Some Aspects of the Medical Treatment of Hypertension."

Second District

(COUNCILOR: RAY M. TURNER, M. D., SPRINGFIELD)

CLARK

Dr. Alex J. Steigman, chairman, Department of Pediatrics, University of Louisville School of

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Medicine, was guest speaker at the April 20 meeting of the Clark County Medical Society. His topic was virus diseases.

Among actions taken by the Executive Council was approval of the following resolution: "Whereas the Clark County Medical Society approves the principles of UAF and one fund drive for all affiliated agencies, it must, therefore, disapprove of separate drives to solicit local funds for medical purposes. Further, the Medical Society does not approve of any group withdrawing from UAF to mount a separate drive."

Another action of the Council was to authorize appointment of a committee to work with Wittenberg College for the mutual benefit of both doctors and the school.

Third District

(COUNCILOR: FLOYD M. ELLIOTT, M. D., ADA)

LOGAN

A joint meeting of the Logan and Champaign County Medical Societies was held Thursday evening (April 2) at the Bellefontaine Country club.

Following dinner the speaker was Dr. Harry LeFever, Columbus, professor and head of the neurosurgery department at Ohio State University. Dr. LeFever talked on the management of headaches.

Nine physicians were present from Champaign county. (Fourteen were present from Logan County.)—*Bellefontaine Examiner*.

Fourth District

(COUNCILOR: W. W. GREEN, M. D., TOLEDO)

DEFIANCE

A project of the new \$150,000 addition to the city hospital which will include a new operating room, post-recovery room and a nursery locker room was discussed at the May 9 joint meeting of the Defiance County Medical Society and the members of the staff of Defiance City Hospital. Also at the same meeting, Dr. Alfred Rhoden, a pathologist from Toledo, presented a new form for the uterine cancer detection program.—Julian Movchan, M. D., Correspondent.

LUCAS

The May schedule of events for the Academy of Medicine of Toledo included the following features:

May 1, General Section—"Current Trends in Medical Education," Dr. Walter S. Wiggins, secretary of the AMA Council of Medical Education and Hospitals.

May 6 and 7, Inter-Hospital Postgraduate Lec-

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August 3-14, 1959


The United States Section of the International College of Surgeons will again offer its Annual Postgraduate Course, in cooperation with the Cook County Graduate School of Medicine. It will be a two-week intensive review course in General Surgery presented at the Graduate School, and in the wards and operating rooms of Cook County Hospital.

The program will include illustrated lectures, anatomy demonstrations, operative clinics and practice surgery by the participants on anesthetized dogs. Consideration will be given not only to surgical technic, surgical complications and management of the surgical patient, but also to an intensive review of the basic sciences in relation to clinical surgery.

Registrations for the course will be limited.

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ture Series, featuring the theme "Endocrine Problems of Clinical Significance; Modern Concepts," by Dr. S. Leon Israel, professor of obstetrics and gynecology, University of Pennsylvania.

May 15, Medical Section—Joint meeting of the Academy and the Medical Assistants Society of Toledo and Lucas County; a panel discussion by Dr. R. J. Borer, chairman, Advisory Committee to the Medical Assistants; Drs. A. E. Rhoden and Paul Geiger, members of the committee; also Mrs. Ruth Walkowiak, immediate past-president of the State Assistants Society, and Mrs. Alison Noon, immediate past-president of the local society.

May 22, Surgical Section—"Comprehensive Care of the Patient with Gynecologic Malignancy," Dr. W. Beryl Silberblatt, clinical professor of obstetrics and gynecology, New York Medical College.

SANDUSKY

Refresher course sponsored by the Sandusky County Medical Association Wednesday (April 1) afternoon and evening at Memorial Hospital was well attended with medical men from Tiffin, Port Clinton, Elmore, Delta, Oak Harbor, Gibsonburg, Woodville, Old Fort, Green Springs, Bellevue, Bettsville, Clyde and Fremont present.

A total of 42 attended the afternoon sessions and 45 were present for the evening. Guest speakers were from Ohio State University, Columbus.

The afternoon session began at 2 p. m. and was divided into two parts lasting until 5 p. m. A social hour was enjoyed until 6, when dinner was served. The evening meeting began at 7.

A team from Ohio State University College of Medicine presented the program. Those on the program were Dr. William Copeland, Department of Obstetrics and Gynecology; Dr. Robert Watman, Department of Surgery; Dr. Samuel Saslaw, Department of Medicine.

Dr. W. M. Hindman, pathologist at Memorial hospital, was in charge of arrangements and reservations for the meeting.—*Fremont News Messenger*.

The Sandusky County Medical Society held its regular meeting at Serwin's Restaurant, Fremont, on April 15 with 18 members present. Dr. William Havener, Ohio State University, Columbus, spoke on "Eye Injuries."

Sixth District

(COUNCILOR: ROBERT E. TSCHANTZ, M. D., CANTON)

MAHONING

The Mahoning County Medical Society is sponsoring a series of radio programs over Station WKBN, Youngstown, under the title of "Consultation." The public is invited to phone in

questions to be discussed by a panel of local doctors.

STARK

Dr. William L. Proudfit, of the Cleveland Clinic, was guest speaker at the April 9 meeting of the Stark County Medical Society in Canton. His subject was "Thrombosis of the Carotid Artery." The local newspaper reported 75 persons present at the meeting.

SUMMIT

Dr. Herbert J. Rinkel was guest speaker for the May 5 meeting of the Summit County Medical Society in Akron. His subject was "The Symptomatology of Allergy in Relation to All Branches of Medicine." Dinner was served at the Akron City Club with the meeting following in the Akron City Hospital Auditorium. Dr. Rinkel, along with Dr. Z. Z. Godlowski, also presented a program under sponsorship of the Akron Academy of Ophthalmology and Otolaryngology, May 4-6.

TRUMBULL

"Low Back Pain" was the topic of discussion at the April 15 meeting of the Trumbull County Medical Society. The speaker was Dr. Floyd Bragdon, professor of surgery, University of Pittsburgh. The dinner meeting was held at the El Rio Restaurant, Warren.

The new format of the constitution and bylaws of the Society has received final approval and at last report was nearing readiness to be distributed to members.

Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

BELMONT

The Belmont County Medical Society with the Auxiliary met on April 16 at the Belmont Hills Country Club for dinner and a program. The subject, "Low Back Pain," was discussed by Dr. C. B. Buffington, of the Wheeling Clinic.

TUSCARAWAS

The Tuscarawas County Medical Society had as its guest speaker at the April meeting Dr. William H. Havener, of the faculty of Ohio State University, who discussed "Chronic Simple Glaucoma and Eye Trauma," and who demonstrated the use of a tonometer.

Drs. A. J. Abelson and W. R. Bush were elected to active membership in the Society.

A constitutional amendment to create separate offices of secretary and of treasurer in the society was enacted.

Articles of incorporation of the Society were presented and accepted; leading to the incorpora-

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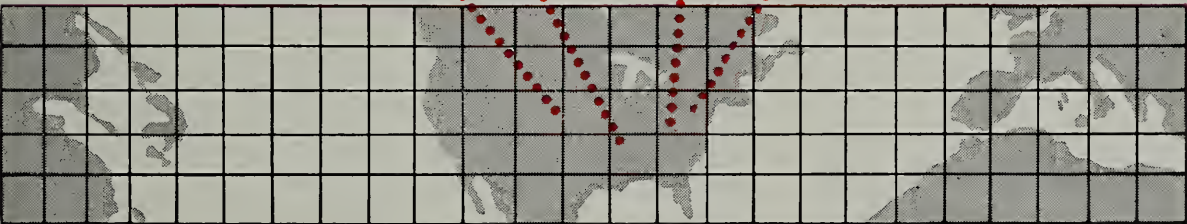
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For adult tension and anxiety	25 mg. tablets Syrup	one tablet q.i.d. one tbsp. q.i.d.	• References: 1. Smigel, J. O., et al.: J. Am. Ger. Soc., in press. 2. Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958. 3. Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957. 4. Menger, H. C.: New York J. Med. 58:1684 (May 15) 1958. 5. Coirault, M., et al.: Presse méd. 64:2239 (Dec. 26) 1956. 6. Bayart, J.: Presented at the International Congress of Pediatrics, Copenhagen, Denmark, July 22-27, 1956.
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tion of this Society.—G. D. Woodward, M. D., Secretary.

Eighth District

(COUNCILOR: WILLIAM D. MONGER, M. D., LANCASTER)

LICKING

The Licking County Medical Society held its monthly meeting Tuesday evening (March 31) at the Granville Inn. Participants in the program were Paul W. Reed, managing editor of *The Newark Advocate*; Robert H. Pricer, commercial manager of Radio Station WCLT; Richard Athey, executive director of Newark Hospital, and John Fisher, executive secretary of United Appeal of Licking County.

These men as a panel made brief talks in their respective fields in their relationship to the doctors' medical news and its release to the community. This was followed by an interesting and highly informative period of questions by the president, Dr. K. J. Fleisch, and other members of the Society, which were answered by the panel.

Dr. William D. Monger, of Lancaster, Eighth District Councilor, Ohio State Medical Association, was a guest and gave some pertinent factors affecting the medico-legal aspects of the society. The meeting closed after a short business session. *Newark Advocate*.

The Licking County Medical Society, at its February meeting, had Judge Charles B. Holtsberry, of the Common Pleas Court, as guest speaker on the subject of "The Doctor and the Law," followed by an interesting question and answer session. The Society and the Auxiliary are again sponsoring Nursing Scholarships this year.—J. R. Wells, M. D., Secretary.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

HOCKING

The Hocking County Medical Society was host to the Hocking County Bar Association at a din-

ner meeting in the home of Dr. George Watson, president of the Medical Society. Dr. Watson presided at the meeting which was devoted to discussion of topics of common interest to the two groups.

SCIOTO

"Treatment and Care of Head and Neck Injuries," was the subject discussed by Dr. William Hunt, neurosurgeon at University Hospital, Columbus. The evening program in the Nurses Recreation Hall of General Hospital, Portsmouth, was followed by a buffet supper.

Tenth District

(COUNCILOR: ROBERT M. INGLIS, M. D., COLUMBUS)

FRANKLIN

The May 20 program of the Columbus Academy of Medicine featured the second annual joint meeting with members of the Columbus Bar Association. The Program format included an educational session of equal interest to both physicians and attorneys, a social hour followed by dinner and an after-dinner speaker.

The Neil House ballroom was the scene of the program. A film, "The Man Who Didn't Walk," was shown as produced by the American Medical Association Legal Department in cooperation with the American Bar Association.

A panel discussion followed on the subject "Traumatic Neurosis." Moderator was Attorney Earl F. Morris; panel members, Gordon E. Williams, Richard L. Miller, Dr. George T. Harding and Dr. Dwight M. Palmer. A tape recording "Jury Deliberations" also was presented.

Speaker of the evening was the Honorable Tennyson Guyer, Senator from Hancock County.

The big event for the Academy during April was the Annual Meeting of the Ohio State Medical Association, for which the Academy was official host. A great deal of preparation on the part of Academy members went into this event.

(Continued on Page 892)

GROUP LIFE INSURANCE

for Members and their Employees

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Location	Facility	Telephone
Akron	Children's Hospital W. Bowery and W. Bechtel	BL 3-5531, Ext. 246
Cincinnati	The Academy of Medicine of Cincinnati 152 E. Fourth St.	PA 1-2345
Columbus	Children's Hospital 561 S. 17th St.	CL 8-9783
Cleveland	Cleveland Academy of Medicine 2121 Adelbert Road	CE 1-4455
Springfield	City Hospital E. High St. and Burnett Rd.	FA 3-5531, Ext. 226
Toledo	Toledo Health Department 635 N. Erie St.	CH 4-1961—(Day) GR 9-2244—(Night)

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CAPSULES—14 VITAMINS—11 MINERALS

Each capsule contains:	
Vitamin A	5,000 U.S.P. Units
Vitamin D	500 U.S.P. Units
Vitamin B ₁₂ with AUTRINIC [®]	
Intrinsic Factor Concentrate	1/15 U.S.P. Oral Unit
Thiamine Mononitrate (B ₁)	5 mg.
Riboflavin (B ₂)	5 mg.
Niacinamide	15 mg.
Folic Acid	1 mg.
Pyridoxine HCl (B ₆)	0.5 mg.
Ca Pantothenate	5 mg.
Choline Bitartrate	50 mg.
Inositol	50 mg.
Ascorbic Acid (C)	50 mg.
Vitamin E (as tocopheryl acetates)	10 I.U.
L-Lysine Monohydrochloride	25 mg.
Rutin	25 mg.
Ferrous Fumarate	30 mg.
Iron (as Fumarate)	10 mg.
Iodine (as KI)	0.1 mg.
Calcium (as CaHPO ₄)	157 mg.
Phosphorus (as CaHPO ₄)	122 mg.
Boron (as Na ₂ B ₄ O ₇ · 10H ₂ O)	0.1 mg.
Copper (as CuO)	1 mg.
Fluorine (as CaF ₂)	0.1 mg.
Manganese (as MnO ₂)	1 mg.
Magnesium (as MgO)	1 mg.
Potassium (as K ₂ SO ₄)	5 mg.
Zinc (as ZnO)	0.5 mg.

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Many members served on committees and other wise contributed their time and effort toward making the Annual Meeting a success. Members of the local Woman's Auxiliary played important parts as hostesses and committee members.

MADISON

Dr. Hugh Payton, Fayette County physician, and staff member of the Fayette County Memorial Hospital, was guest speaker at the April meeting of the Madison County Medical Society held in London.

Dr. Payton stated that the Fayette County Memorial Hospital medical and surgical departments are operating at more than capacity and predicted similar occupancy of available space in the community hospital to be constructed in Madison County. He further pointed out that the hospital with its annual payroll represents a sizeable factor in the economic life of the community.

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

LORAIN

The regular meeting of the Lorain County Medical Society was held at the Oberlin Inn, April 14. There were 59 members present.

Dr. Abraham Klar, Lorain, and Dr. R. S. Vandervort, Elyria, were both elected to active membership.

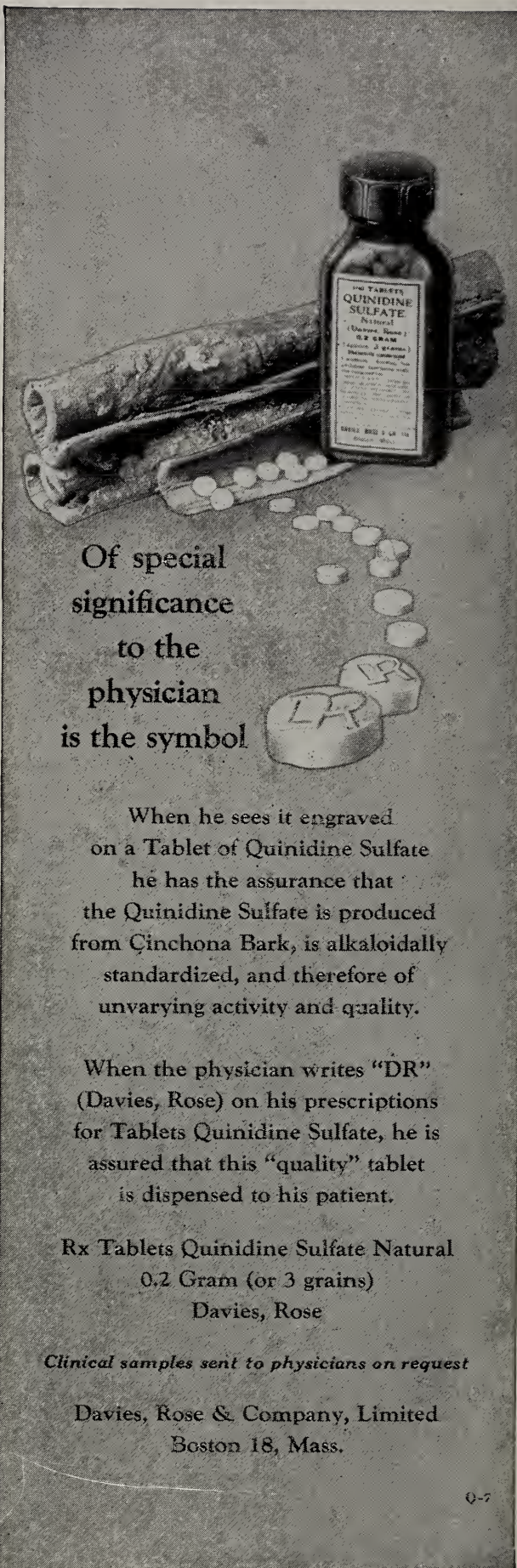
The meeting consisted of reports by the following committees: Liaison with County Welfare, O. H. Schettler; Legislative, Paul J. Kopsch; Education, James T. Stephens; Insurance, John W. Wherry; Special Committee on Osteopaths, Conrad Rusin.—Lawrence C. Meredith, M. D., Secretary-Treasurer.

The Society sponsored a panel discussion before a meeting of the Fields Parent-Teacher Association. Featured on the panel were Dr. William Wladecki, Dr. Theodore Berg, Dr. Ward Young and Dr. R. W. Johnson (dentist).

RICHLAND

The Richland County Medical Society held its regular monthly meeting at the Westbrook Country Club, Thursday, April 16, and had as a speaker Dr. Emerich Szilagyi, who gave an excellent talk on blood vessel surgery of the extremities. Doctor Szilagyi is chief of the surgical service at Henry Ford Hospital in Detroit, Michigan, and is a well known specialist in his field.

Dr. R. E. Frush, president, conducted the business meeting, and the speaker was obtained through the efforts of Dr. W. Max Brown.—James O. Ludwig, M. D., Secretary.



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When he sees it engraved
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Northridge, California

Activities of Woman's Auxiliary . . .

CHAIRMAN PUBLICITY COMMITTEE—Mrs. W. J. Horger,
1100 Ohio Ave., East Liverpool, Ohio
(See Page 750 for roster of officers.)

COLUMBIANA

Mrs. V. E. McEldowney, Mrs. A. S. Fisher, Mrs. Charles Gerace, and Mrs. C. H. Bailey were hostesses at a coffee hour for the Columbiana Medical Auxiliary on April 14 at the home of Mrs. McEldowney of Newell, W. Va.

Mrs. William Banfield, president, welcomed 18 members and the following guests: Miss Nell Robinson, superintendent of East Liverpool City Hospital, Miss Ruth Burell, dietitian, Mrs. Sarah Davis, directress of nurses, and Miss Frances Jones, librarian, City Library. Mrs. R. J. Bonestelli was welcomed as a new member.

The following officers were elected for the coming year: President, Mrs. A. P. Falkenstein; president-elect, Mrs. K. W. Turner; vice-president, Mrs. A. M. Simpson; secretary, Mrs. C. J. Lehwald; treasurer, Mrs. Leonard Pritchard.

Three hundred dollars was sent to AMEF.

Miss Frances Jones reviewed the book *The Great Oildorado* by Dotson.

LUCAS

The following items were taken from the 1958-1959 budget of the Woman's Auxiliary to Academy of Medicine of Toledo and Lucas County:

American Medical Education	
Foundation	\$1,523.50
Citizens Committee for Family	
Life Education	10.00
Citizen's Day Care for Children	10.00
County Fair Project	50.00
Essay Contest	65.00
Memorial Gifts to AMEF	75.00
Mother's March Tea	100.00
Nurse Recruitment Tea	150.00
Nurses' Scholarships	400.00
"To-Day's Health" Gift to Schools	50.00
	<hr/>
	\$2,433.50

This was the way Lucas County Auxiliary

the "full-range"
oral hypoglycemic agent

DBI

Trademark, brand of Phenformin

in the management of
mild, moderate and severe diabetes
(juvenile and adult)

members spent hard earned money. It was their way of saying to the Medical Association "We are proving our worth as an Auxiliary."

MAHONING

The Woman's Auxiliary to the Mahoning County Medical Society held a spring buffet luncheon at the Tippecanoe Country Club April 15 in conjunction with the Woman's Auxiliary to the Columbiana County Medical Society.

The speaker for the day was Dr. Sidney Berkowitz who gave a humorous talk entitled, "I'm Telling You Children for the Last Time."

Officers for the coming year were elected during the business meeting. Mrs. A. E. Rappoport will succeed the retiring president, Mrs. Earl H. Young. Mrs. Arnoldus Goudsmit is the president-elect. Other officers are Mrs. Ben S. Brown, vice-president; Mrs. Frank Gelbman, recording secretary; Mrs. J. J. Wasilke, corresponding secretary; Mrs. S. G. Patton, Jr., treasurer.

Mrs. William H. Evans, Mrs. A. E. Rappoport and Mrs. Paul Mahar attended the convention of the Woman's Auxiliary to the Ohio State Medical Association in Columbus April 21-24.

Members of the newly formed Auxiliary Bowling League held a banquet to which their husbands were invited on April 29 at Tippecanoe Country Club. Trophies were presented to members of the winning team.

SCIOTO

Mrs. Otto P. Apel, Jr., opened her home for the April 8 meeting of the Woman's Auxiliary of Scioto County Medical Society. Mrs. Otto F. Apel, Sr., and Mrs. J. A. O'Leary were guests.

The guest speaker was R. A. Dauber of Cincinnati, state representative for the National Foundation, which originally organized for the study and research of infantile paralysis. Mr. Dauber explained the new expanded program which the foundation began last July.

A question and answer period followed the speaker's informative talk.

Mrs. Armin A. Melior presided at the business meeting which was followed by a social hour.

ERIE

The Woman's Auxiliary to the Erie County

DBI

(N1- β -phenethylbiguanide HCl) is an entirely new oral hypoglycemic compound, different in chemical structure, mode of action, and in spectrum of activity from the sulfonylureas. DBI is usually effective in low dosage range (50 to 150 mg. per day).

"full-range" hypoglycemic action—DBI lowers elevated blood-sugar and eliminates glycosuria in mild, moderate and severe diabetes mellitus...

brittle diabetes, juvenile or adult—DBI combined with injected insulin improves regulation of the diabetes and helps prevent the wide excursions between hypoglycemic reactions and hyperglycemic ketoacidosis.

stable adult diabetes—satisfactory regulation of diabetes is usually achieved with DBI alone without the necessity for insulin injections.

juvenile diabetes—DBI often permits a reduction as great as 50 per cent or more in the daily insulin requirement.

primary and secondary sulfonylurea failures—DBI alone, or in conjunction with a sulfonylurea, often permits satisfactory regulation of diabetes in patients who have failed to respond initially or who have become resistant to oral sulfonylurea therapy.

smooth onset—less likelihood of severe hypoglycemic reaction—DBI has a smooth, gradual blood-sugar lowering effect, reaching a maximum in from 5 to 6 hours, and a return to pretreatment levels usually in 10 to 12 hours.

safety—daily use of DBI in therapeutic dosage for varying periods up to 2½ years has produced no clinical toxicity.

side reactions—side reactions produced by DBI are chiefly gastrointestinal and occur with increasing frequency at higher dosage levels (exceeding 150 mg. per day). Anorexia, nausea or vomiting may occur—but these symptoms abate promptly upon reduction in dose or withdrawal of DBI.

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Medical Society met May 3 for luncheon at the Charter House in Bellevue.

The nominating committee submitted the following slate of officers: President, Mrs. C. F. Lavender; president-elect, Mrs. Richard Williamson; vice-president, Mrs. Edward Gillette, Jr.; secretary, Mrs. H. L. Hoffman; treasurer, Mrs. D. V. Auld.

Installation of the new slate of officers followed. Mrs. Paul LaFollette, retiring president, was installing officer, and pinned a corsage on each new officer.

Special honor was given auxiliary members present, who have been married to their doctor husbands for twenty-five years or more. An appropriate poem was read by Mrs. Richard Williamson for this group of ten. Unique corsages were made for each. Among an array of colorful spring flowers, were nestled such items as tongue blades, cotton balls, band aids, Q tips, and pills.

During the business meeting annual reports were given by committee chairmen. Mrs. Richard Williamson and Mrs. C. F. Lavender, delegates to the Ohio State Medical Convention, gave their report on this meeting. Mrs. Edward Gillette, Jr., also attended as alternate.

Members made baby bibs for Good Samaritan Hospital's Pediatric Department, at the April meeting.

SUMMIT

The Woman's Auxiliary to the Summit County Medical Society met for brunch on May 5 at the Akron City Club. Mrs. C. A. Colombi, Cleveland, president of the Woman's Auxiliary to the Ohio State Medical Association, installed officers for 1959-60. The new officers are: President, Mrs. Robert J. Hemphill; president-elect, Mrs. A. H. Kyriakides; vice-president, Mrs. B. F. Suffron; recording secretary, Mrs. Simon A. Schlueter; corresponding secretary, Mrs. R. H. Gollings;

treasurer, Mrs. James G. Roberts. Following the installation ceremony, the meeting was transformed into a party to honor the past-presidents of the Summit County Auxiliary.

World Conference on Medical Education in Chicago

The Second World Conference on Medical Education will be held in Chicago, August 29 - September 4. The conference is sponsored by the World Medical Association in collaboration with the World Health Organization, the Council on International Organizations of Medical Sciences and the International Association of Universities. Details may be obtained from the World Medical Association, 10 Columbus Circle, New York 19, New York.

Voluntary health insurance coverage is increasing faster among people 65 and over than among any other age group in the country. Forty-three per cent of the population 65 and older now has such insurance— an increase of almost 40 per cent in the last five years.—Health Information Foundation.



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50 individual cozy cottages, some with light housekeeping, on Fairview Lake in the Pocono Mts. (Altitude 1600 ft.) Ideal naturally wooded setting. Secluded, safe, perfect for the whole family. Children's activities, sandy beach.
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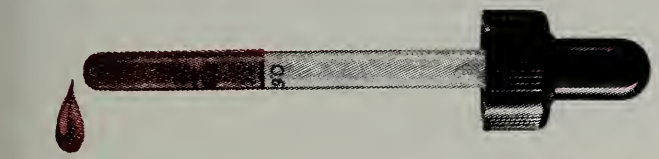
HERBERT A. SIHLER, JR., Sec'y.

MEMBER: American Hospital Association — Central Neuropsychiatric Hospital Association
National Association of Private Psychiatric Hospitals

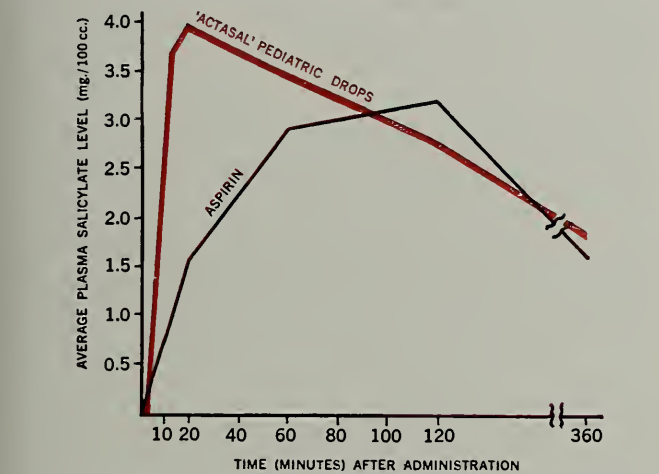
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Comparative Plasma Salicylate Levels After Oral Administration of Doses of 'Actasal' Pediatric and Aspirin, Providing Equal Amounts of Salicylate.

Clinically proved - In thousands of cases by more than 180 investigators⁴
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A new and unique salicylate molecule in palatable solution.

DOSAGE: Each dropperful (0.6 ml.) contains 105 mg. Choline Salicylate, equivalent to approximately 1¼ grains aspirin.

Children 6-12 years: 2 to 4 dropperfuls every 3 to 4 hours, or as required. Children 3-6 years: 1 to 2 dropperfuls every 3 to 4 hours, or as required. Children under 3 years: 1 dropperful every 3 to 4 hours, or as required.

SUPPLY: 60 cc. bottle packaged with cellophane-wrapped calibrated dropper.

CITED REFERENCES: 1. Smith, P. K.: Personal Communication. 2. Wolf, J., Aboody, R.: Federation Proc. 18:605, 1959. 3. Broh-Kahn, R. H.: Federation Proc. 18:17, 1959. 4. Complete data available on request to the Medical Director.

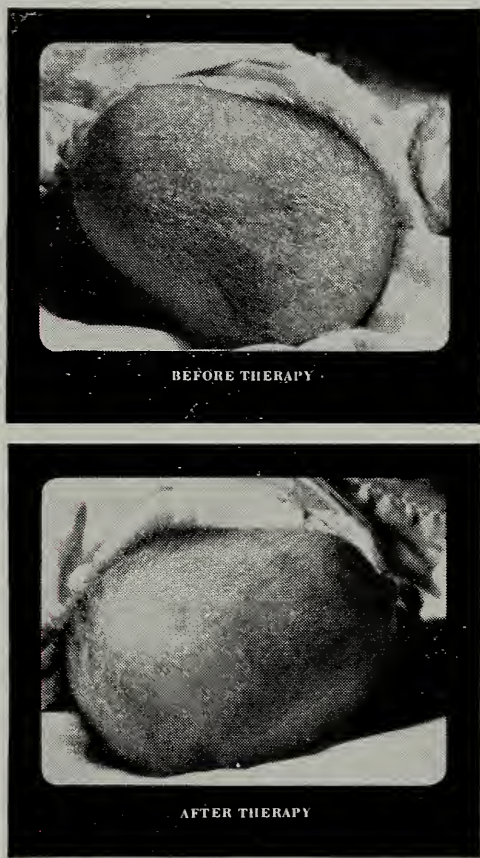
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CONTAINS CERAPON-C* 12.0% IN PROPYLENE GLYCOL WITH PARABENS 0.1% AND TYROTHRIN 0.1%, PURDUE FREDERICK *BRAND OF TRIETHANOLAMINE POLYPEPTIDE COCOATE-CONDENSATE

Specifically prepared for safe, effective removal and prevention of cradle cap, by combining unique proteo-lipid sebulytic effect with anti-infective action.



Bialkin, G.: Scientific Exhibit, American Academy of General Practice, San Francisco, April 6-9, 1959.

CASE HISTORY: J. D., a 5 month old white male developed a dry seborrhea capitis at approximately 6 weeks after birth which covered the whole scalp. By the time of examination, the child had been treated with various detergent ointment and lotion preparations without apparent effect. 'Soropon' Pediatric Solution was applied as a shampoo, directly to the scalp to remove the encrustations. A lanolin ointment was applied to scalp because of inherent dryness. A series of 5 treatments was required for complete removal and after this treatment period the seborrheic eczema had virtually disappeared. The patient has been symptom free since then.

Bialkin, G.: A New Anti-Seborrheic Agent in Pediatric Practice. Arch. of Ped. (to be published).

SUPPLY: 'Soropon' Pediatric Solution is available in bottles of 4 oz.

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COMING MEETINGS

American Medical Association, Annual Session, Atlantic, City, N. J., June 8-12.

American Roentgen Ray Society, Cincinnati, September 21-25.

Chest Disease Symposium for General Practitioners, Saranac Lake, N. Y., July 6-10.

Cincinnati General Hospital, Course in Diagnostic Roentgenology, Week Beginning June 15.

Northwestern Ohio Medical Association, Findlay Country Club, October 7, all-day session; registration 9:00 a.m.; first speaker, 9:45 a.m.

Ohio Chapter, American College of Surgeons, Annual Meeting, Statler Hotel, Cleveland, September 11, 12.

Ohio State Medical Golfers' Association, 1959 Tournament, Acacia Country Club, Cleveland, June 18.

Ohio State University, Department of Ophthalmology, Course in Perimetry for Office Assistants, July 13-15; Course for Ophthalmology Secretaries, July 16-17.

Ohio State Surgical Association, 1959 Annual Meeting, Cleveland, June 3-4.

Medicare Office Delineates Emergency Categories

The Office for Dependents' Medical Care has defined requirements of physicians to substantiate claims covering emergencies and acute surgical conditions.

Medicare has ruled that the judgment of the charge physician is relied on to substantiate such claims, emphasizing, however, that the acute or emergency condition must be medical or surgical—not socio-economic.

In the case of an emergency requiring hospitalization, the physician is required to state: "The Case was a bona fide acute emergency."

For surgical emergency, an acceptable certification is: "An acute condition existed requiring hospitalization, without delay, for the purpose of carrying out surgery at the earliest practicable time."

A similar statement is required for acute medical conditions. However, admission of patients not actually ill for diagnostic surveys will not be payable. Medicare office states that a physician's diagnosis on the claim form must be consistent with any clinical facts in the emergency.

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Rates: 50 cents per line. Minimum charge of \$1.00 for each insertion. Prices cover the cost of remailing answers. Forms close 15th of the month preceding publication. To assure prompt delivery, when replying to an advertisement over a *Journal* box number, address letters as follows: Box (insert number), c/o The Ohio State Medical Journal, 79 East State St., Columbus 15, Ohio.

Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus 15. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

PHYSICIAN'S OFFICE FOR RENT. Well established general practice. Office equipment and furniture for sale. Mrs. Robert A. Thornton, 43 E. Tompkins St., Columbus 2, Ohio; Phone AM 2-9829.

FOR RENT: 4-Rm. Office Suite for physician in Fostoria, Ohio. Ground floor, 1½ blocks from Main St., near Post Office; parking for physician's car in rear; local 40-bed hospital municipally owned. K. S. Rowe, 225 W. Center St., Fostoria, Ohio.

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WANTED: Chief Resident Physician to supervise approved two-year General Practice Residency program. Hospital is in an area needing General Practitioners. Applicant must be graduate of U. S. Medical School and have completed at least two years of training in either Internal Medicine or General Practice. Stipend open for discussion. Apply: Administrator of Robinson Memorial Hospital, Ravenna, Ohio.

HAVING ACCEPTED FULL-TIME POSITION, my office and practice are available. Carpeted, acoustic tile ceilings, air conditioned and wired for intercom and radio. Approx. 1200 sq. ft. 1st floor, recently constructed and carefully planned for 1 or 2 physicians. Two doors from corner drug store and about midway between the three hospitals. Parking area. John M. Van Dyke, M. D., 836 Auburn Pl., N. W., Canton 3, Ohio.

WANTED: Staff Physician for 800 bed hospital for the mentally ill. Excellent medical facilities, including new Medical-Surgical Clinic and Receiving Hospital. Applicant must be graduate of Grade A Medical School and licensed to practice medicine in Ohio. Write: Milton P. Smith, M. D., Superintendent, Tiffin State Hospital, Tiffin, Ohio.

EQUIPMENT, RECORDS AND SUCCESSFUL GENERAL PRACTICE. Space for two in modern Medical Center with ample parking facilities. R. H. Snyder, M. D., Academy of Medicine of Toledo, 3101 Collingwood Blvd., Toledo.

FOR RENT: Space available Aug. 1st in air-conditioned building, 1103 Mt. Vernon Ave., Columbus, for dentist. Will consider any other professional man. R. Earl Bland, M. D., Phone CLearbrook 3-7372, Columbus.

E. N. T. DOCTOR, licensed in Ohio, finishing his otolaryngology residency training including endoscopy and allergy in one of the largest hospitals, affiliated with State University of New York and Long Island College of Surgeons, eligible for specialty board, wants association with group. E. N. T. practitioner or surgeon preferably in Cleveland or vicinity of Cleveland. Box 133, c/o Ohio State Medical Journal.

OPPORTUNITY: Medical Publisher has salaried position for physician as Consultant in Consulting Bureau and Editorial Departments. Regular hours, 5 day week permanent and rewarding. If desirable personal interview can be arranged. W. F. Prior Company, Inc., Medical Publishers, Hagerstown, Maryland.

EXCELLENT OPPORTUNITY for anyone interested in general practice in growing community of 13,000 near Lake Erie. Hospital in town. Leaving to specialize July 1, 1959. Wilfred B. Dodgson, M. D., 150 Milan Ave., Norwalk, Ohio

PHYSICIAN'S OFFICE AND EQUIPMENT FOR SALE, in center of town; population 2500; 5 other towns around with no doctor; gross \$48,000; taking residency July 1; will sell below cost; good hospital 15 minutes drive with staff privileges readily available. Box 131, c/o Ohio State Medical Journal.

FOR SALE: EENT instruments and equipment; good condition; many could be used by general surgeon. Box 127, c/o Ohio State Medical Journal.

PRACTICE FOR SALE: Columbus, O.; Jas. G. Alcorn, M. D., eye specialist deceased April 29; lease \$50 monthly; 10,000 histories. Ellinger, 50 W. Gay St., Columbus; CA 8-3251 or HU 8-9803.

FOR RENT: Ideal for doctor's office and medical center; no doctor in shopping center or apartments at present; good location Westgate Manor Apartments and Shopping Center, 3600 Sullivant Ave., in Columbus; over 1900 families in radius of one-half mile and growing all the time; air conditioned; plenty of parking space. For further information address: 587 Wedgewood Dr., Columbus 4, Ohio; Telephone BRoadway 9-9431.

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VA Hospital Admission Evaluation Now Includes Dental Exam

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MADISON—William T. Bacon, President, 40 E. First St., London; Paul G. H. Wolber, Secretary, 40 E. First St., London. 2nd Wednesday, monthly.

MORROW—Andrew Maciurak, President, 119 E. Main St., Cardington; William S. Deffinger, Secretary, Marengo. First Tuesday, monthly.

PICKAWAY—Henry H. Swope, President, 233 N. Court St., Circleville; Edward L. Montgomery, Secretary, 108 Seyfert Ave., Circleville. 1st Friday, monthly.

ROSS—Robert E. Quinn, President, 30 N. Walnut St., Chillicothe; G. Howard Wood, Secretary, 134 W. Main St., Chillicothe. 1st Thursday, monthly.

UNION—Paul R. Zaugg, President, 130 N. Maple St., Marysville; May B. Zaugg, Secretary, 130 N. Maple St., Marysville. 2nd Tuesday, monthly.

ELEVENTH DISTRICT

ASHLAND—R. Lee Schafer, President, 203 Maple Street, Ashland; Wayne C. Smith, Secretary, 140 Claremont Ave., Ashland. 1st Friday, monthly, except July, August.

ERIE—Richard F. Hoffman, President, Providence Hospital, Sandusky; Edward P. Gillette, Jr., Secretary, 410 Columbus Ave., Sandusky. Monthly meeting date varies.

HOLMES—Clyde Bahler, President, Walnut Creek; Luther W. High, Secretary, R. F. D. 4, Millersburg. 2nd Wednesday, monthly.

HURON—Walter A. Drury, President, Box 269, Willard; John V. Emery, Secretary, Box 269, Willard. 2nd Wednesday, March, June, September and December.

LORAIN—Denis A. Radefeld, President, 209 Sixth St., Lorain; Mrs. C. Ruth Zealley, Executive Secretary, 311 Elyria Block, Elyria. 2nd Tuesday, monthly.

MEDINA—Robert E. Smith, President, 403 East Liberty St., Medina; William G. Halley, Secretary, 115 Bank Street, Lodi. 3rd Thursday, monthly.

RICHLAND—Riley E. Frush, President, 36 S. Mulberry St., Mansfield; James O. Ludwig, Secretary, 336 Sturges Ave., Mansfield. 3rd Thursday, monthly.

WAYNE—Ralph I. Cottle, President, 230 N. Market St., Wooster; Robert E. Schulz, Secretary, Wooster Community Hospital, Wooster. 2nd Wednesday, monthly.

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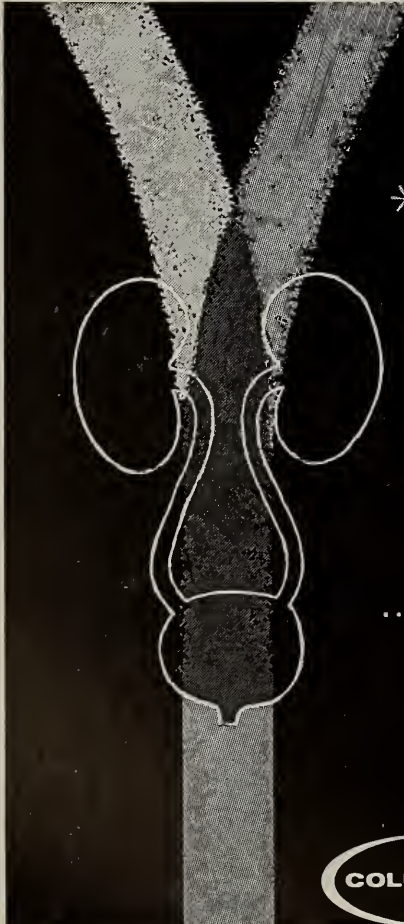
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more conservative and manageable than full-
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THERAPY SHOULD BE INDIVIDUALIZED

acute conditions: Two or three tablets four times daily. After
desired response is obtained, gradually reduce daily dosage
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Acetylsalicylic acid	325 mg.
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References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

Schering

The Physician's Bookshelf

(Books received from publishers. *The Journal* is not obligated to list herein every book received. It will try to list those which appear to be of greatest interest.)

* * *

Cerebral Vascular Diseases: Second Conference, by Irving S. Wright, M. D., and Clark H. Millikan, M. D. (\$4.00, *Grune & Stratton, Inc.*, New York 16, N. Y.) This text consists of the minutes of the second conference on cerebrovascular disease, which have been edited very little. This method of presentation makes for easy reading and tends to hold the interest of the reader. A formidable collection of papers, the text summarizes current thinking in this difficult and somewhat controversial field. It is highly recommended reading.

Subjects covered range from studies of cerebral circulation through studies of experimental cerebrovascular disease and dysfunction to very practical aspects of treatment both surgical and medical including enzymes and anticoagulants.

Appended to this text is "A Classification and Outline of Cerebral Vascular Diseases," reprinted from *Neurology* (Volume VIII, pp. 185 to 216), which should be of value to those interested in this field.

Principles of Internal Medicine, edited by T. R. Harrison, M. D., Raymond D. Adams, M. D., Ivan L. Bennett, Jr., M. D., William H. Resnik, M. D., George W. Thorn, M. D., M. M. Wintrobe, M. D. (\$18.50, Third edition, *Blakiston Division, McGraw-Hill Book Company*, New York 36, N. Y.) This third edition of Dr. Harrison's text features an impressive list of contributions and is organized, as were the preceding editions, with a discussion of "common denominators" followed by descriptions of specific diseases and disease agents. It is an excellent text both for reference and for teaching. Part Two, Cardinal Manifestations of Disease, should be required reading not only for medical students but also for practicing physicians.

Making the Most of Your Years, by Evelyn Hart. (25 cents, Public Affairs Pamphlet No. 276, *Public Affairs Pamphlets*, New York 16, N. Y.)

The Family Medical Encyclopedia, by Justus J. Schifferes and others. (\$4.95, *Little, Brown and Company*, Boston 6, Mass.)

The Plasma Proteins; Clinical Significance, by Paul G. Weil, M. D. (\$3.50, *J. B. Lippincott Company*, Philadelphia 5, Pa.)

Radiographic Atlas of Skeletal Development of the Hand and Wrist, by William Walter

Greulich and S. Idell Pyle. (\$15.00, Second Edition, *Stanford University Press*, Stanford, Calif.)

Varied Operations, by Herbert A. Bruce, M. D. (\$6.75, *Longmans, Green and Company, Inc.*, New York 18, N. Y.)

Maternity: A Guide to Prospective Motherhood, by Frederick W. Goodrich, Jr., M. D. (\$1.75, *Prentice-Hall, Inc.*, Englewood Cliffs, New Jersey.)

New Biology 28, by M. L. Johnson, Michael Abercrombie, G. E. Fogg. (65¢, *Penguin Books Incorporated*, Baltimore 11, Md.)

Health in Industry, by Donald Hunter. (95¢, *Penguin Books Incorporated*, Baltimore 11, Md.)

Childbearing Before and After 35, by Adrien Bleyer, M. D. (\$2.95, *Vantage Press, Incorporated*, New York 1, N. Y.)

Textbook of Surgery, by H. Fred Moseley and contributors. (\$17.00, Third edition, *The C. V. Mosby Company*, St. Louis 3, Mo.)

Call the Doctor, by E. S. Turner. (\$3.95, *St. Martin's Press, Inc.*, New York 10, N. Y.)

Open Door To Health, by Fred D. Miller, D. D. S., introduction by Victor Heiser, M. D. (\$3.95, *The Devin-Adair Company*, New York 10, New York.)

Mannerisms of Speech and Gestures in Everyday Life, by Sandor S. Feldman, M. D. (\$5.00, *International Universities Press*, New York 11, New York.)

Anatomy for Surgeons; The Back and Limbs, by W. Henry Hollinshead. (\$23.50, Volume 3, *Paul B. Hoeber, Inc.*, New York 16, N. Y.)

Therapeutic Radiology, by William T. Moss, M. D. (\$12.50, *The C. V. Mosby Company*, St. Louis 3, Mo.)

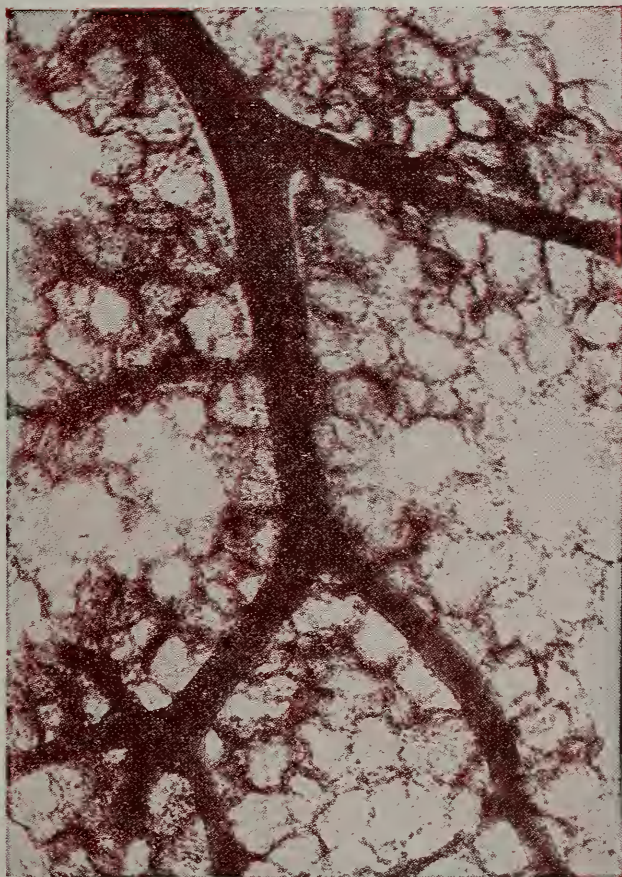
Antibiotics Annual 1958-1959, by Henry Welch, Ph. D., and Felix Marti-Ibanez, M. D. (\$12.00, *Medical Encyclopedia, Inc.*, New York 22, New York.)

Playing for Life, by William F. Talbert with John Sharnik. (\$4.00, *Little, Brown and Company*, Boston 6, Mass.)

General Urology, by Donald R. Smith, M. D. (\$4.50, Second edition, *Lange Medical Publications*, P. O. Box 1215, Los Altos, California.)

ARISTOCORT IN ANTIHISTAMINE COMBINATION


Steroid-Antihistamine Compound LEDERLE



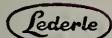
comments by clinical investigators:

"I would conclude that ARISTOMIN is truly a worthwhile aid in treating allergic problems."¹

"The results have been uniformly good. The patients have stated that their symptoms were very much relieved. I have not encountered any side reactions except from one patient, who complained of some drowsiness, which I attribute to the antihistamine."²

"In general . . . it [ARISTOMIN] is an excellent product. Over-all, it appears to be more effective than any simple antihistamine we have used. Despite the fact that we employed it in the treatment of a variety of nonselected individuals and problems, we had excellent and good results in 25 of the 39 patients."³

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DERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

You and Your Public

Patient's Attitude Toward Medical Profession Based Mostly on Personal Experience

YOUR committee believes that the best medical care is a personal experience which somehow must be understood and appreciated by the public, rather than a commodity to be 'sold' by traditional methods."

That statement, pegging public relations on the physician-patient relationship, is made by Malcolm S. Watts, M. D., in the May issue of the California Medical Association Newsletter.

Chairman of the CMS Public Relations Committee, Dr. Watts points out that many physicians would like to have someone else solve all their problems in professional public relations.

Here it should be pointed out that such an attitude is foolhardy. This wishful thinking would mean a shifting of responsibility from the shoulders of the individual to some other source. There is overwhelming evidence in other fields as to what happens when responsibility is shifted away from the individual.

Living Relationship

Dr. Watts writes that "* * * public relations is basically a living expression of the doctor-patient relationship in the home, the office, the hospital, the community and the state. This is obvious for professional patient care. It is also applicable to social and economic problems in medicine."

He defines the doctor-patient relationship as:

1. The need of the patient to be helped.
2. The physician's desire to help.
3. The patient's belief that the doctor can and will help.
4. The tool or technology by which the help is given.

It would be well to add to this:

5. Mutual understanding of fees and their payment, and
6. What is best for the patient.

In discussing the importance of the economic aspects of physician-patient relationship, Dr. Watts writes:

"Rising prices which affect all costs, scientific advances which make medical care more complex and expensive, inflation which reduces purchasing power, together with taxes have combined to create a situation in which the individual needs

help in financing his medical care. This constitutes a medical need. Many individuals or families cannot finance an expensive illness or sometimes even preventive or maintenance care from out of pocket funds or savings.

Recognition Slow

"It is suggested that the medical profession as 'physician' has been slow to recognize this bona fide health need of its 'patient'—the public. Individual doctors always have assisted their individual patients, but the profession itself has been slow to cooperate in solving the fundamental problems. It often has appeared to act only under pressure. In consequence, the patient's belief that the doctor can and will help has been weakened, and in this very real sense the doctor-patient relationship has failed. The unsatisfied 'patient,' exercising his right of free choice, sometimes consults other 'doctors' whose economic cures are rumored to be more effective."

In other words, medicine's somewhat tardy movement to assume more responsibility in considering the economic aspects of medicine has permitted interests outside the profession to grant themselves self-appointed responsibility for this economic situation. The result is history. It also is history that these self-appointed 'doctors' lacked the knowledge and understanding of medicine and the physician-patient relationship necessary to administer these assumed responsibilities.

Essential to Best Care

Dr. Watts remarks, "This should not be surprising. Most physicians will concede that the doctor-patient relationship is essential to the best professional care for the individual patient. Many will concede that it is the only important distinction between personal and collective medicine. Upon reflection it seems equally clear that it also is the core of sound relationships between the organized profession, as 'physician,' and the public, as 'patient.'"

He concludes, "Thus, medical public relations is not something to be bought for the office or for the community. It entails a recognition of the professional, social, economic and political needs of the patient, evidencing the physician's desire for help, strengthening the patient's belief that the doctor can and will help, and improving the tools



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Leading authorities always have recognized the value of brewer's yeast, but the necessity of giving a patient 30 to 40 large tablets a day has limited the usefulness of this valuable vitamin source. Now—*one* teaspoonful of NABCON a day will give the same results—results often significantly superior to synthetic B complex mixture.

Whether the patient is 3 years or 80 years old, for gratifying clinical response and willing patient co-operation, prescribe NABCON in 4 oz. bottles—a month's supply.

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WORCESTER, MASS.

*Have you
tasted NABCON?
It's really pleasant.
Send for samples.*

by which the help is given. It is, simply, living and expressing the doctor-patient relationship. No one can do this for us."

Void Is Dangerous

What happens when there is a void in this relationship? There are plenty of interests outside the profession who are eager to rush in and attempt to fill such a void. A professor of sociology at one of the nation's largest universities showed evidence of this recently. While serving as a panel member at a meeting of more than little interest to medicine, he expressed the opinion that physicians and their patients were no longer capable of handling their responsibilities and therefore responsibility for the medical care of the individual should be invested in some central authority.

It stands to reason that the physician can best prevent non-medical interests from interfering simply by maintaining a full doctor-patient relationship. This eliminates any void, thereby eliminating opportunity for outside interests to interfere with this relationship.

Long-Range Study of Smog Victims Shows Interesting Effects

Residents of Donora, a Pennsylvania mining town of 12,000 which hit the nation's headlines in 1948 because of a smog which resulted in the death of 20 people, have since shown a substantially higher prevalence of cardiovascular and respiratory diseases, increased hospitalization and more chronic asthma and bronchitis than their nonaffected fellow citizens, according to a recent report.

It was the first study of its kind on the long-term effects of a potent smog, undertaken by the University of Pittsburgh School of Public Health.

"The relationship of particular contaminants in the Donora air to specific symptoms could not be pinned down," the report said, but "the smog, in essence, also brought out or accentuated previous disease.

"For the period since the smog, the death rate among men in the affected group is more than twice that of nonaffected males," the report continued. "The difference in the mortality of the two groups showed up within one year after the 1948 smog and increased steadily until 1954, when it apparently stabilized."

Concluding that affected citizens showed a higher rate of current symptoms and a higher prevalence of chronic illness, the differences were apparent in most ages and sex classifications, "even the group under 20," according to the report.

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Physiologically Standardized
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HIPPOCRATES—Medicine Becomes a Science—reproduced here is one of a series of original oil paintings commissioned by Parke-Davis.

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Diagnosis of disease by means of touch, hearing, and close observation was advocated by Hippocrates. This kindly, dedicated Greek physician practiced in the fifth century B.C. He is revered worldwide as the "Father of Medicine." There emerged from his teachings a system of professional practices based on natural study and rational inquiry, which replaced older systems based on magic and superstition.

The ethical principles laid down by this ancient preceptor guide the modern physician, whose chief concerns are the welfare of his patients and careful study of their individual needs. With the aid of today's

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Washington Roundup

News from the Nation's Capital of Interest to Physicians; Developments in Medical and Health Fields

Medical care price index for first quarter of 1959 is up slightly, according to survey completed May 1. Index stands at 149.6 (1947-49-100). In 10 selected cities, the index ranged from a high of 191.9 in Minneapolis to low of 137.6 in New York City.

* * *

Public Health Service reports that first 19 weeks of 1959 recorded 301 cases of paralytic polio, compared with 160 for same period in 1958. Commented Dr. John D. Porterfield, Acting Surgeon General, May 25, "We are at least two months away from the polio peak and there is still time to reverse this upward trend" through vaccination.

* * *

Plan of Federal Aviation Agency to withhold pilot certification from person with cardiac, diabetes and psychiatric conditions, and to require Class III (private) pilots to get their physical examinations exclusively from designated examiners has encountered objections from pilots, airport operators, flying associations and many physicians.

* * *

Internal Revenue Service has ruled as tax deductible sick pay given a woman from time of onset of labor to end of her physical incapacity caused by childbirth or miscarriage. Otherwise, to qualify, a woman must have her physician certify that absence from work is to guard against miscarriage.

* * *

In another tax case, a U. S. District Court has ruled that an elevator installed in a residence of a woman with acute coronary insufficiency is tax deductible as a medical expense. A physician prescribed the installation.

* * *

Food poisoning which broke out among labor unionists entrained from Ohio to Washington has been identified by Public Health Service as *Clostridium perfringens*, a bacterium more commonly known in England than in the United States.

* * *

New Army surgeon general is Major General Leonard B. Heaton, succeeding Major General

Silas B. Hays, who retired June 1 and became American Red Cross eastern region medical director.

* * *

Aerospace Medical Association (formerly Aero Medical Association) will have new and permanent headquarters in Washington, with Dr. William J. Kennard, former head of AMA Washington office, in full time charge of AeMA headquarters.

* * *

Bureau of Labor Statistics is modernizing its consumer costs unit mechanism for determining sums spent for health conservation. For example, physician panel which reports "typical" fee figures has been increased in size from six to 18.

* * *

National Cancer Institute's analysis of 38,000 cancer cases in 10 cities indicates a "definite" connection between incidence and socio-economic status. Institute reported that rates generally were highest in the lowest income groups and lowest in the highest income groups.

Review Shows Distribution of Nurses in State of Ohio

Some interesting information on the distribution of registered nurses in Ohio was contained in a recent issue of *The Ohio Nurses Review*, published by the Ohio State Nurses' Association. Here is the tabulation as given in the review:

Distribution of Employment in Ohio

	Number
Ohio, actively employed	23,062
Ohio, not actively employed	7,153
Ohio, activity status not known	50
Outside Ohio	1,056

Total nurses registered in Ohio 31,321

Type of Employment

Hospital or other institution	13,803
School of nursing	650
Private duty	3,186
Public health other than school nurse	1,107
School nurse	397
Industrial nurse	1,499
Office, doctor or dentist	1,985
Hospital and school of nursing	118
Other	144
Field of employment not reported	173

Total actively employed in nursing in Ohio 23,062

(Prepared for ANA by the Service Bureau Corp.)

NO SALT *..but seasoned*



A meal of even the most colorful and the most meticulously prepared food can be dreary eating without salt. Neocurtasal, for the patient on a low-sodium diet, brings back flavor to foods—makes eating a pleasure once more.

Neocurtasal[®]

An excellent salt replacement
for
“Salt-Free” (Low Sodium) Diets

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New York 18, N.Y.

*Assures patient's
cooperation*

*Contains potassium chloride,
potassium glutamate,
glutamic acid, calcium
silicate, potassium
iodide (0.01%).*

2 oz. shakers and
8 oz. bottles

Sold Only Through Drugstores

ents to properly instruct these boys and girls of the methods of seeking medical service by calling for appointments and stating the nature of the service they seek.

"I have also instructed the various superintendents that I will not perform this service myself except upon the presentation by a minor of a note signed by his superintendent stating the person to be indigent and unable to obtain free service from another physician. It is my belief that I should have very few such examinations to perform."

HERE'S CHANCE TO PRACTICE SOME PREVENTIVE MEDICINE

Private practitioners have the opportunity to practice some preventive medicine in a non-medical field. We refer to the growing number of suffocations by children playing with plastic bags.

The National Safety Council reports that 20 children suffocated in the first three months of 1959 while playing with the plastic containers over their heads. Safety experts predict that the 1959 death total will reach 100.

The plastic material, which is airtight, adheres closely to the face, completely blocking the nose and mouth. This adhesive quality is increased many times when the container becomes charged with static electricity, and the plastic has a strong tendency to acquire static charges.

In our opinion, physicians can contribute considerably to the growing campaign against these suffocations by warning all the patients they see to guard themselves and particularly their children against this seemingly innocent material.

EIGHT BASIC RULES TO PREVENT MALPRACTICE

R. Crawford Morris, Cleveland attorney, is one of the outstanding authorities of the country on malpractice. Writing in a recent issue of *GP*, Mr. Morris discussed in detail eight basic rules for the prevention of malpractice suits.

Although most of the rules are undoubtedly well known to most physicians and may sound exceedingly simple, they are reiterated here for the sake of emphasis and warning:

1. Never guarantee a cure unless you mean to be held to it.

2. Watch the time factor. In Ohio the patient has one year within which to sue you for malpractice; you have six years to sue for your bill.

3. Keep up with the advance of medicine.

4. Don't keep too far up. Do not experiment unless you have the patient's permission in writing.

5. Get the patient's consent for everything you do, preferably in writing. Unauthorized

treatment is assault and battery for which the plaintiff-patient can recover without proof of negligence.

6. Keep good records, full and adequate. Have all proper laboratory tests performed and keep results of these tests. Remember, records are called "witnesses whose memories never die."

7. Do not be negligent. If you feel the case is beyond your experience, do not hesitate to call for consultation and make a written record of the consultant's opinion.

8. Develop good public relations. This is your greatest asset. Be considerate of your patients, remembering that their reaction to what you say as well as what you do is important and is governed by a complicated emotional behavior pattern developed over years of sometimes bitter experience. The words you speak may not convey to the patient's mind the communication you intended in your own mind. Be as careful with your tongue as you are with your scalpel.

THEY GROW AND GROW, NEVER SHRINK AND SHRINK

Those who believe in the slogan "let the Federal Government do it" will find something to ponder about—perhaps—in some statistics just released by a Congressional committee concerning the Veteran Administration's 171 hospitals and 17 domiciliaries. They show rather conclusively that government programs most always grow and grow, never shrink and shrink. Here are a few excerpts from the statistical study:

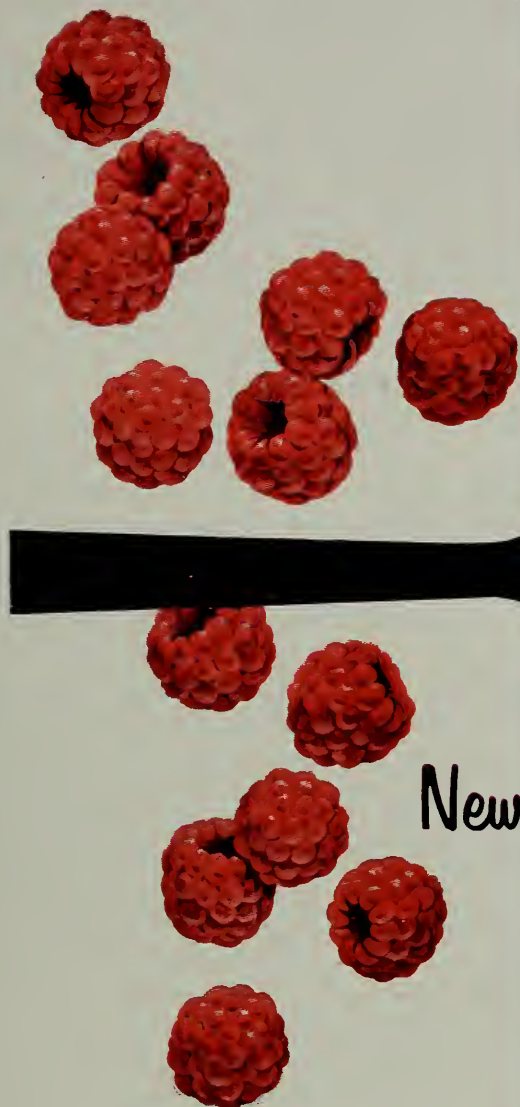
VA's Department of Medicine and Surgery has 128,400 employees, including 4,600 physicians, nearly 800 dentists and about 15,000 nurses. Its physical plant has an estimated value of \$2.5 billion. Rated bed capacity is 126,750 beds. On Jan. 12, 1959, key date of questionnaire survey, the inpatient census was 113,819.

UNIFORM ACCOUNTING BY MEDICAL SCHOOLS NEEDED

The Association of American Medical Colleges is endeavoring to devise a uniform accounting procedure for medical schools. Such a project is long overdue.

Until a uniform method of arriving at and reporting the costs of operating our medical schools can be put into effect nationally, there can be no clear picture of the financial situation in the field of medical education. Moreover, until this is done, economies cannot be put into effect where needed and efforts to increase the revenues of the schools will lag.

Quick action on this by the medical schools is indicated.



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- ✓ Adsorbs toxins and gases
- ✓ Soothes inflamed mucosa
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FORMULA:

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Sulfaguanidine 2 Gm.
Pectin 225 mg.
Kaolin 3 Gm.
Opium tincture 0.08 cc.
(equivalent to 2 cc. paregoric)

SUPPLIED:

Bottles of 16 fl. oz.
Exempt Narcotic.
Available on Prescription Only.

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DOSAGE:

ADULTS: Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

CHILDREN: $\frac{1}{2}$ teaspoon (=2.5 cc.) per 15 lb. of body weight every four hours day and night until stools are reduced to five daily, then every eight hours for three days.

In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

KEEP THESE IN MIND WHEN TESTIFYING

You never know when you'll be called to the witness stand. Are you up on what you'll be expected to do? Obviously, an attorney will (at least should) brief you. However, here are a few points to keep in mind when testifying:

Don't be afraid. The honest physician who comes to court to tell the truth has nothing to fear.

Don't testify as an expert unless you are satisfied that you are qualified in the area of specialization involved.

Don't use terminology which will not be understood by jury, legal counsel or the judge.

Don't neglect to inform your patient's attorney of all unfavorable as well as favorable facts.

Don't regard it as an admission of ignorance to indicate that your opinion is not conclusive. To do otherwise is frequently dishonest.

Don't be smug. A courteous, modest attitude is much more impressive.

Don't give categorical answers in all instances. Often the proper answer should begin with an "if."

Don't lose your dignity, even if an attorney cross-examines you concerning your training, integrity or intelligence.

GIVE YOUR LOCAL EDITOR THE FACTS

A memo recently distributed by the Communications Division of the AMA states that a survey of newspaper clippings reveals that editors are giving more and more space to two subjects: (1) cost of medical care and (2) medical and hospital care for the aged.

The following comment on this in the memo makes a lot of sense and should be a hunch to county society officers and public relations committeemen for local action, when and where needed:

"Incidentally, on the basis of some of the editorials we have seen, there is an apparent need for better follow-up at the local level. When a newspaper editorial expresses criticism of medicine in these two areas, county medical societies especially should consider the advisability of meeting with the editor and discussing these issues with him. We must keep in mind that editors appreciate getting the down-to-earth facts on all issues that confront the American public. They

like to have all of the facts before taking an editorial position.

"Feel free to call on your editor, personally, and acquaint him with medicine's positive views on these issues. Give him the educational material that is now available. Your friendly call will be a rewarding service both to him and to the profession."

SAYS IT IS IN REALM OF PRIVATE PRACTICE

Dr. Robert A. Vogel, Montgomery County Health Commissioner, writing in the Montgomery County Medical Society Bulletin regarding the health certificates which must be furnished by school children applying for work permits takes a position which ought to serve as an example for all county health commissioners of the state.

Section 3331.02 establishes requirements for issuance of employment certificates. One requirement is that a certificate from the school physician or physician designated by him or in the absence of a school physician, the district health commissioner or physician designated by him showing after an examination that the child is physically fit for the types of employment not prohibited by law for a boy or girl under 18 years of age must be submitted to the school superintendent prior to issuance of a work permit.

In an official statement, Dr. Vogel said: "Since the school districts do not employ school physicians the district superintendents have sent all boys and girls wishing work permits to the health department for their physical inspections.

"I am of the firm opinion that this type of service falls naturally in the realm of private practice and therefore am designating each physician of Montgomery County as is provided for in Section 3331.02 of the Revised Code of Ohio as the proper one to provide physical examinations for the purpose of issuing work permits for his private patients and have so informed the superintendent of the school districts of Montgomery County.

"It is my hope that each physician will cooperate and accept this assignment in the interest of preserving the principles of private medicine. It is also hoped that each physician will endeavor to hold the cost of such service to a minimum since many of the boys and girls seeking work permits do so because of family financial problems.

"I have advised the school district superintendent

scores
highest
in clinically
important
tests

METICORTEN[®]
prednisone

Even in long-term therapy, diet and salt
restrictions are usually unnecessary
—a benefit of METICORTEN repeatedly
noted by investigators.

METICORTEN—1, 2.5 and 5 mg. tablets.

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corticosteroid quiz

ANSWERS: 1. False—by altering tissue reaction. 2. False—only hydrocortisone has been so identified. 3. True. 4. False—performed by Brown-Séquard.

damage in one single year than all the epidemics that come upon the people in an age.

"There are too many 'numsculls' as pupils. As soon as a farmer, or mechanic, or a merchant finds that his son is lazy and worthless he sends him to some physician in the neighborhood to study medicine and in a few years the blockhead is dealing out physics and slashing around with the surgeon's knife."

Public Demands Stiffer Penalties

According to an Ohio law in effect at that time, anyone convicted of the illegal exhumation of a corpse or of receiving such remains, knowing them to have been illegally exhumed, was subject to a fine of one thousand dollars and imprisonment in the county jail for six months. Obviously the law was designed to deter the practice of grave robbery then prevalent. That it failed to do so is evident by the case then pending in the Muskingum County Court of Common Pleas as well as many other instances brought to light in the daily press of that period.

Whenever a case of grave robbery in a local community was discovered one of the first reactions of the public was to demand an increase in the penalty provided by the existing law. Usually this demand was made in the form of a resolution adopted at a mass meeting of citizens or in letters addressed to the editors of local newspapers. As might well be expected such letters were very bitter in their denunciation of professional resurrectionists, as exemplified in the following letter addressed to the Editor of the *Zanesville Daily Courier*, under the date line of November 18, 1878:

"Surely, it is time something were done by the legislatures of our country to put a stop to this business. The punishment now for robbing a grave is little, if any, heavier than for robbing a hen-roost. Eastern nations have an imaginary demon, which they conceive preys upon the bodies of the dead, that they call a Ghoul.

"But our ghouls are no imaginary demons. They walk about among us, in broadcloth and kid gloves; physicians and surgeons, with lawyers to defend them, when caught at their obscene work; nice young men, who clerk in stores during the day, take their girls to places of amusement in the evening, and then replenish their depleted pockets by invading the cemeteries, putting hooks through the jaws of our deceased friends, sacking and carting away the bodies, and selling them to Professors of Anatomy for \$25. apiece! This is horrible but it seems to be true.

"The whole business of body snatching is becoming a systematized profession; and it will continue to branch out, and become a more pros-

perous profession, so long as the petty punishment for the offense is a poor six months in the county jail. Let not another Legislature pass by in Ohio, without amending the laws for the protection of the dead. Let the penalty on conviction of grave robbing be from 10 to 30 years in the Penitentiary; with this additional provision, that, if taken in the act, it shall be lawful for any one, policeman, sexton or citizen, to shoot down the ghouls like sheep-killing dogs. Then some good purpose will have been served by the present excitement of all classes of our people."

According to a Zanesville reporter the Doctor had stated to him that he had suggested the idea of a coffin torpedo for the protection of graves to a Columbus artist, who then invented and patented such an article. It consisted of a miniature needlegun about six inches long divided into two pieces, one of which contained a spiral spring and the other attached to it contained a cartridge. To the spiral spring were attached two small chains that were to be fastened around the body or arms of the corpse. The spring gun was nailed inside the coffin and would be detonated whenever a would-be resurrectionist attempted to move the body from the casket.

Newark Citizens Resent Rumors

Rumors were published in some of the Zanesville papers to the effect that one of the accused men had told the Marshal of Newark he had resurrected 60 to 70 bodies from cemeteries in that place the past year. It was also reported that the trustees of Newark cemeteries had had several graves opened in order to verify the claims and that many of the occupants were missing from their graves. Such rumors resulted in arousing the ire of Newark residents. The writer of a letter to the Editor of the *Ohio State Journal* November 21, 1878, said that "Newark sympathizes with Zanesville in her grave robberies but the latter must not manufacture public sentiment against the ghouls at Newark's expense." The claim was refuted that 60 to 70 bodies had been resurrected from Newark cemeteries during the past year because there had been only 36 interments there, 15 of which were stillborn babies.

A special news item from Newark in the same newspaper, November 23, 1878, quoted the Newark Marshal as saying that the report in the Zanesville papers concerning Eaton's statement to him about having taken 60 to 70 bodies from Newark cemeteries was absolutely untrue. The Marshal was quoted as saying that Eaton had told him he had been in Newark about a year ago and had opened four graves in two different cemeteries there but he had taken only one body, since the

others were too badly decomposed for dissection purpose.

The Marshal stated further that so far as he had any knowledge not a grave had been opened in any of the Newark cemeteries by the cemetery boards or others for the purpose of finding out whether any bodies were missing. The writer concluded by saying that "the people of Newark are about tired of this sensational stuff, and so far as they are concerned, for the sake of those who have relatives buried in our cemeteries within the past year, it is hoped it will close, especially so when it lacks all the elements of truth."

Crime and Punishment of a Demonstrator Of Anatomy

The trial of the three accused men took place in the Muskingum County Court House in December, 1878. They entered a plea of guilty of the four counts. When Judge Marsh accused the Doctor of procuring bodies for the purpose of selling them to medical colleges throughout the country the latter denied the charge. He claimed he had received an appointment as Demonstrator of Anatomy in Starling Medical College and that he was merely fulfilling his obligation to the College by providing students with dissection material.

In weighing all the evidence in the case the judge presumably was convinced that the Doctor was primarily responsible for perpetrating the act of unlawfully opening the four graves. At least when he pronounced sentences on the trio he sentenced the Doctor to one year in the Muskingum County jail, three months for each offense, and imposed a fine of \$4,000.00—\$1,000.00 for each offense. His two henchmen were each fined \$100.00 and costs and were committed to jail until their fines were paid.

The Zanesville Signal reported on June 7, 1879, that the three men made an unsuccessful attempt to break jail by sawing through some bars of their cell with a saw which they had improvised out of a table knife, but were apprehended in the act. However, aid did come to them on July 26, 1879, after having languished in jail for over six months, when they were pardoned by Ohio's Governor Richard M. Bishop. In spite of this turn of events the people of Zanesville apparently were satisfied that justice had already been done. At least when the news of the pardon was announced in the press the comment was made that the prisoners were only an expense to the county anyhow and their release from jail served to lessen the burdens of the tax payers. Thus ended an episode in Ohio History which threatened for a time to endanger friendly relations between three central Ohio sister cities.

Cleveland Health Museum Development Program Is Given Impetus

A ten thousand dollar grant from the Cleveland Foundation launches the Cleveland Health Museum on the second phase of its \$106,000 Development Program.

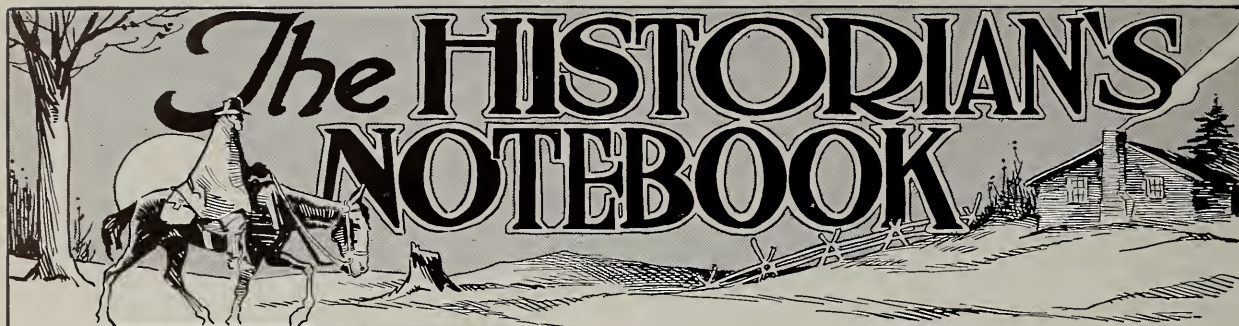
This money will be used to build exhibits for a modern "Wonder of New Life" room in the Health Museum. The actual models of the birth of a baby, which have fascinated young and old for years, will be supplemented by exhibits showing all physical and mental facets of creating a new life. The male and female reproductive system, the sperm and egg cells, cell division, the growth of the embryo are all shown in three-dimensional exhibits. These are followed by displays on the growth of the fetus and birth of the child.

The inheritance of personal characteristics, the determination of sex, and the reasons for multiple births, are explained by exhibits on human heredity. The last group of displays pictures a most important problem for mother, father, sisters, brothers and the new child—mental health. To bring a baby into the proper environment each member of the family must know what his problems are and what his part in creating happiness will be.

The "Wonder of New Life" is part of an exhibit building program which will include Community Health displays and at least six temporary exhibits each year. These special exhibits will concern current health problems.

Hospital in Action, by Lucy Freeman. (\$5.00, *Rand McNally Company, Chicago 80, Illinois.*) This is the story of the Michael Reese Medical Center. It recounts a dedicated service with all of the miracles, the pathos and tragedies that go on in such an institution as they can be written up by a medical reporter from the *New York Times*. The author of **Fight Against Fears** has made a most dramatic story out of the 75 years that this well known medical center has contributed knowledge to the care of premature infants, polio vaccines, the processing of blood and plasma, research into heart disease, cancer, ulcers and tuberculosis.

The **Tuberculin Skin Test** has been used in detecting tuberculosis in cattle since 1890 when tuberculin was first prepared by Robert Koch. Its accuracy has stood the test of time and usage as one of our most reliable diagnostic reagents in animals.—J. E. Williams, D. V. M., Ph. D., Washington, D. C.: *J. Lancet*, 79:212, May, 1959.



A Ghoulish Tale of Three Cities

LINDEN F. EDWARDS, Ph. D.

PART II

(Concluded from June Issue)

IN AN INTERVIEW granted a reporter of a local newspaper Eaton said he had taken the clothes he was wearing from a dead body he had resurrected a year or so ago. He also admitted to the police that he had paid a visit to a Zanesville cemetery two weeks ago but did not "lift" the body because of its high state of decomposition.

The following day his two confederates were arrested, taken to Zanesville and lodged in jail. Within two days the Grand Jury of Muskingum County brought an indictment against the three men of willfully opening four graves without lawful authority. The attorneys employed by the defendants as Council were Mr. Frank Southard and the Honorable George K. Nash who secured their release from jail on payment of bail fixed at \$4,000.00 by the Judge of the Common Pleas Court.

A Newspaper's Denunciation Against Medical Colleges

In the interval prior to their appearance in court many wild rumors concerning the body snatching activities of the accused men commanded the attention of the public and the daily press. The Doctor was accused of being the leader of a resurrection gang, of operating a wholesale cadaver bootlegging business in providing medical colleges throughout the country with dissection material, of having a pickling vat in his residence where bodies were stored and prepared for shipment to other cities and even of being in cahoots with Dr. Morton, the notorious resurrectionist.

Heaped upon these accusations in the Zanesville press were charges of negligence against the Columbus police who were even accused of being in collusion with the resurrectionists. Columbus newspapers refuted these accusations and defended

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the police department, which denied emphatically the charges made against it.

Illustrative of the bitter feeling of the Zanesville press against medical colleges, physicians and professional resurrections is the following editorial which appeared in the *Zaneseville Daily Courier* on Nov. 18, 1878:

"In all parts of the country are established medical colleges. In fact a second class city is not thought to be complete unless a medical college is established within its limits. Here collect ignorant professors to lecture to still more ignorant pupils. Surgery? Not one in a hundred knows anything whatever about surgery. But bodies must be secured to make the brainless pupils believe the brainless professors know something about surgery.

"These brainless youths, who will soon be turned out to prey, like a set of harpies, upon the people, must be taught, however, to make sport over the remains of some body, which has been stolen from where relatives and friends have tenderly placed it. It is a most disgraceful thing that the people are preyed upon by ignorant blockheads who sail under the name of physicians. In fact the ignoramuses, who have attended lectures a couple of winters and are turned out to prey upon the honest laboring men and their families, do more

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Asst. Managing Editor

Premenstrual Tension Syndrome and Psychogenic Dysmenorrhea*

EDUARD EICHNER, M. D.

SYMPTOMS of premenstrual tension were known long before Frank⁸ first used the expression in 1931. At about the same time Novak described patients with menstrual and premenstrual molimina.¹² This complex was originally thought to be the result of excess estrogens, and treatment consisted of catharsis and diuresis in an attempt to get rid of this excess. As ovarian steroids were identified, each in turn assumed a major responsibility for this condition—Premenstrual Tension Syndrome (PTS). Investigators disagreed as to whether or not excess amounts, inadequate amounts or mere imbalances were the primary etiologic factors. When these failed to account for the symptoms other causes of salt retention were sought. The pituitary gland and its antidiuretic hormone were next inculpated. Yet adequate diuresis does not completely cure, nor does it prevent this disability.

Jitteriness and a craving for sweets were identified with hypoglycemia^{11,14} and hyperinsulinism in some patients. Furthermore, because of the varied degree and extent of the many tensions, the neurovegetative approach to the solution has also been reported as successful. Eichner and Waltner have summarized these and other concepts.²

PTS Defined

The major difficulty in any review of the literature, particularly on a topic such as premenstrual tension, is the lack of unanimity in the various

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reports which vary even as to the description of the treated complex. Although almost all speak of "Premenstrual Tension Syndrome," many include symptoms associated with the actual flow, and may embrace tensions and other symptoms which persist throughout the month as well as those not aggravated by or associated with the premenstrual period. In some this period starts with ovulation, and may be present without it. Others limit their cases to those symptomatic during the 7 to 10 days preceding the menses. In some patients these complaints may recur cyclically in the absence of menstruation, even well beyond the clinical climacteric.

In questionnaires given to patients suffering from premenstrual tension, and to groups of nurses acting as controls, the response could be modified by the type of question. When patients with PTS sought relief, approximately half had emotional symptoms as their primary complaint. Only one-fifth complained of congestion. When responding to the questionnaire, however, three fourths admitted symptoms associated with con-

*Presented at The Scientific Assembly of The Ohio Academy of General Practice, Toledo, Ohio, October 1958.

gestion, symptoms which for the most part were accepted without difficulty and tended to be ignored.

Frequency

The responses of the nurse controls were almost identical, but less than 7 per cent thought their condition grave enough to warrant treatment. Even those accepting treatment were not constant in attendance. On the other hand, private patients were anxious to accept any hope for relief. The fact that congestion was not a primary complaint in the majority of patients treated may explain why adequate dehydration by diuresis did not give satisfactory relief.

So long as there is no agreement as to what PTS is, there can be no true meeting of the minds as to its significance. There is ample evidence that women in general—70 per cent in our control group—experience symptoms of premenstrual tension. Many are not aware that they suffer, but their co-workers know and often feel the full effects of the irritability and irascibility manifested by the patient. Interpersonal relationships are frequently inharmonious, and many domestic tragedies result in part from PTS. Some may wonder which came first, but many husbands admit to being worn down by repeated episodes of tension. They give evidence that it is the monotonous regularity of the repetitious assault which finally causes the breakdown.

Psychic Implications

Bickers and Woods⁶ and Billig and Spaulding⁷ report on industrial losses associated with impaired efficiency secondary to PTS. Pollack¹³ has reported unpremeditated criminal acts performed by women during the premenstrual period. Perr⁵ suggests that an attorney "might use the concepts of PTS in arguing mitigating circumstances," but admits that the greater the degree of character defect, the less likely is treatment of the tension alone to be of any help. Because of these social and industrial implications, the premenstrual tension syndrome deserves adequate medical treatment.

As stated previously, this complex varies with each reporter. Despite the vagaries of history taken, and despite the many facets of symptoms and complaints, these can be grouped into three major categories. In our experience the most frequent primary complaint was emotional in type. Physical discomfort sometimes approaching that of true pain was present as the primary disability in about one third of the patients. Least frequent were those complaints associated with congestion: weight gain, edema, swollen breasts, bloating, etc.

Specificity of Routine Treatment

For success the primary complaint must be treated adequately. Should the physician select his patients only from the group with congestive symptoms, any nontoxic diuretic will effect an excellent response. Should the therapist be interested only in patients with pain, analgesics will be eminently successful. Should the practitioner be inclined toward the psyche, any proper "normalizer" will work. But should he be interested in the patient as a whole—and these patients need that kind of a doctor—much more than any one of the preceding remedies will be needed.

In view of the complexity of the symptom patterns one is not surprised that the etiologic agent has not been discovered. Nothing yet explains all symptoms in all patients. Deficiencies, excesses and imbalances of the female hormones have been considered most frequently as causal. The literature is replete with reported successful treatment by estrogens, progestins and combinations of these. Since water retention is frequently present, an allergic response to these steroids has been suggested, as has been an over-activity of or an over-responsiveness to endogenous antidiuretic substance. This has been treated with diuresis. Changes in or modifications of the pituitary-adrenal-ovarian axis have been suspected, but as with all other theories, conclusive proof is still lacking.

There then remains that imponderous causal group, the catch-all, autonomic imbalance. This phase not only hides and covers our ignorance, but stresses it. From the cortex or the medulla through the hypothalamus to the autonomic nervous system, involving somewhere en route the endocrine axis, is the path along which will someday be found the cause of premenstrual tension syndrome.

Meanwhile, we classify this syndrome as a part of the group of neuro-vegetative disturbances. Thus we account for the great variety of symptoms, as with each patient it is "to each his own." This may also explain the variable responses and successes to all types of therapy as well as the large number in whom symptoms disappear when understanding (by either the patient or the doctor) is achieved. This is very evident when the patient is aware that treatment can give adequate relief.

Experimental Routine

Over 300 patients with PTS have been studied. Treatment has been kaleidoscopic in its technical variation including diet, diuresis, steroids, stimulants, tranquilizers and various combinations of these. At the first visit each patient is placed

on a high protein-low sodium (220 mg/day) diet, and is asked to fill out a premenstrual tension diary^{††} in the interval preceding her next visit. This occurs approximately one month later when the diary is complete for one full cycle. At this visit the diary, the patient's symptoms and her response to diet are discussed and evaluated. She is constantly reassured, and she is assured that ample relief is obtainable by one of several available methods of treatment. The fact that an attempt will be made to fit the proper treatment to her rather than to fit her to any standard treatment is stressed at each visit.

Diuresis Not Fully Therapeutic

Patients with adequate responses to diet alone are not otherwise treated. Institution of the strict diet varied from "all month" to after the 15th day of the cycle, according to the patient's needs. Failures on diet were then placed on one of the diuretics, and were asked to continue their dietary restrictions. In the early days of the study diuretic therapy was started about 10 days before the expected onset of flow. Because of the irregularities of the cycle and the occasional undesirable side effects, treatment is now withheld until symptoms develop. It is discontinued with relief. This has the additional advantage of accentuating the relief obtained by the patient, as treatment is given only when the need is present.

Invariably weight loss was adequate, but the overall response was not as satisfactory. The patient with the greatest weight loss (over 10 pounds) retained her tension headache, although bloating and breast congestion were minimized. Enteric coated tablets of ammonium chloride reached the anal canal intact in three patients. Small groups were treated with the newer non-mercurial diuretics, but there seems to be a very great variability in the patient-dose-response curve. Apparently adequate diuresis failed to relieve all the symptoms even though "congestion" disappeared.^{††}

Multidimensional Treatment

Those who obtained relief on any regimen were kept on that particular course of treatment unless toxic side effects warranted discontinuation of therapy. Failures, or successes with undesirable side effects, were then placed on multidimensional tablets (Pre-Mens®) containing caffeine, homatropine and B-complex, with ammonium chloride as a diuretic. Some patients received this tablet with added amphetamine, some with reserpine. Some received an identical looking placebo. The therapeutic tablet gave most consistently good results in our hands.

Medication was started when symptoms occurred and was discontinued with relief, or in five days, whichever came first. If relief had not occurred during the specified period, treatment was considered a failure on the first course. Treatment, however, was not considered as successful unless it had worked adequately for at least three consecutive cycles. The low salt diet was used concomitantly.

When reserpine was added there was a moderate intensification of relief in some patients despite a relative diminution in the diuretic effect. Substituting amphetamine for the reserpine did not enhance the successful response but did accentuate irritability and insomnia. Halving the amphetamine dose had an ameliorating effect. However, I am told that in the Latin-American countries amphetamine is the most important ingredient in the treatment of this complex. In England and the Low Countries, ethisterone is the treatment of choice. A new series has been started recently on a polypharmaceutical ethisterone tablet, but it is too early to evaluate results.

Steroids Seldom Used

In general we have eschewed the use of steroids for fear of upsetting a cycle in an already disturbed patient. Lately several synthetic progestogens* were made available, and have been used cyclically in patients with PTS. The results have not been as satisfactory as those achieved by the multi-dimensional therapy. Two new polyvalent products have also been tried. The first contains acetazolamide, atropine, hyoscyne and tridihexethyl iodide in immediate and sustained release capsules. The second consists of ethisterone, bromotheophylline, chlorpropenpyridamine, salicylamide, caffeine and perphenazine. Neither has been given adequate trial, but in a small group over several months each has already exceeded the success rate of the so-called specifics, and is superior to the diuretics and progestogens alone among our patients,^{††} again demonstrating that the premenstrual tension syndrome is many-sided in all aspects.

Placebo Reactors

Most failures were evident within the first month. Successfully treated patients when placed on a placebo immediately recognized it for what it was because of the absence of effect. Others offered the placebo first, frequently had initial good results. These usually downgraded rapidly to poor results within three to four months. In

*These were also used in the treatment of dysmenorrhea and include norethynodrel, norethindrone, norethandrolone and two substituted progesterones.

all probability the original good response was caused by our assurance that benefit could be obtained. It is this effect which makes analysis of results so difficult. Almost all patients can be fooled briefly. This result is prolonged, however, in only a very few subjects.

One notable phenomenon when treatment was successful was the decreased need for therapy regardless of the medication used. The patient had to be convinced that relief was available at any time should she require it. In fact many required no further treatment after a few months, secure in the knowledge that their medication was available in the medicine chest for immediate use should the necessity ever arise. This diminishing requirement was least evident in those patients most troubled by symptoms associated with edema.

Psychogenic Dysmenorrhea

Despite the apparent complexities of PTS, it is "psychogenic dysmenorrhea" which offers the real problem in semantics. Dysmenorrhea is usually translated as painful menses. Pain is subjective. "Subjective" is defined as "existing in the mind." "Psychogenic" is "of psychic origin, or dependent on psychic conditions or responses." "Psychic" and "mental" are synonymous. Only one conclusion is now possible: all dysmenorrhea is of psychogenic origin. For simplicity, however, today's discussion will be limited to primary, or functional, dysmenorrhea. Types which will not be discussed include those associated with gynecic neoplasms, infections, inflammations, malpositions or displacements, hypoplasia, cervical or vaginal atresia or stenosis, endometriosis, etc. It must be remembered that an occasional "primary" dysmenorrhea becomes "secondary" after the completion of a thorough investigation.

Despite the foregoing psychic overlay in dysmenorrhea, Golub and his co-workers³ concluded after a survey of secondary schools in Philadelphia that dysmenorrhea cannot be cured by psychologic suggestions as used by them. Approximately 20 per cent of their teen-agers were cured spontaneously, while a slightly smaller group developed dysmenorrhea during the period of study. It is possible that the first group suffered because of apprehension, and that dysmenorrhea disappeared with knowledge. It is also possible that the onset of ovulation was responsible for the development of this condition in the second group, as it is now considered by many that true primary dysmenorrhea occurs only in the presence of ovulation.

History and Examination

The physician must take a complete history at the first visit, and should do a thorough physical

examination as soon as feasible. Rectal examination should be included, and must be done if the introitus is not marital. However, this part of the examination may be delayed one or two visits, or until there is full rapport between the patient and her doctor. At no time should the patient be aware that her physician is undecided as to the nature of her condition. He must assure her that relief is immediately obtainable, and that cure is possible well within the not-too-distant future. It is for this reason that the oncoming menses should be free of pain.

If adequate time is available, ovulation should be inhibited by oral estrogens or the newer progestational drugs. If time is not available the patient should be given medication for the control of pain. It is well to remember that codeine is nauseating to some, that Percodan® produces dizziness and weakness, and that meperidine is habit forming. Some of the newer non-narcotic analgesics are rather inconstant in their effect, so that "adequate" dosage should be given the first time. This may be decreased at a later period. Bendectin® twice daily for several days preceding the expected onset of flow has been of great value in preventing or minimizing discomfort.

At the time of the first examination, gynecic disease should be ruled out. At times examination under anesthesia is required, but this may often be deferred, or dismissed. The cervico-uterine canal should be sounded to rule out obstruction, and to determine the relative length of the cervix to the entire canal. Vaginal spreads and basal body temperature charts will verify ovulation. Endocrine deficiencies per se seldom have a specific relationship to the onset or cure of dysmenorrhea. When the confidence of the patient has been gained, and when she knows that relief by some method or other is available, then the diagnostic survey may be continued. Avitaminosis and anemia should be overcome.

Nonspecific Treatment

Through clinical experience we have learned that dysmenorrhea is frequently aggravated by pelvic congestion, by a lowered tolerance to pain, by vigorous exertion or prolonged standing, and by excessive nervous or emotional fatigue. This last is another euphonious phrase to cover our ignorance. However, the key to the solution is that these girls should lead a relatively quiet, healthful and harmonious life. This is our opportunity to do a bit of superficial psychotherapy as this may help the patient understand and appreciate her own problems.

Thus far we have grouped all patients with primary dysmenorrhea together, yet there are

some who suffer only while bleeding, and some whose pain disappears with the onset of the flow. Still others stop bleeding at the height of the pain, to restart when discomfort has disappeared. We have assumed tissue swelling, myometrial ischemia and/or spasm as direct causes, yet Diehl and Hundley¹ found motility normal. Relaxin has been tried with inconstant success.^{9, 10}

Antispasmodics

Except for its sinful nature, alcohol is still one of the best uterine antispasmodics. This accounts for the great success achieved in the past by several nostras, including that bottled by Lydia Pinkham. Other antispasmodic drugs include the belladonna series (atropine, hyoscine, papaverine), anticholinergic drugs (Banthine®, Bentyt®, Prantal®), phenothiazines (Phenergan®, Trilafon®), mephenesin and benzyl benzoate. These should be used for several days preceding the expected period.

An opposite attack on this condition is made by the use of amphetamines which apparently elevate the patient's mood so that she is not disturbed by the pain. Recently, however, codeine has been added to one of these (Edrisal®) to increase its effectiveness. Morton⁴ has reported excellent results using intravenous amphetamine at the height of the attack. Some patients develop "crying jags" but most become euphoric.

It is appropriate here to tell of a recent survey made to pretest among student nurses a new drug combination in the treatment of dysmenorrhea. Two tablets were available. These were identical except for added amphetamine in one. Each contained a new analgesic, an antispasmodic and high dose of niacin along with other B factors. Some students, previously treated satisfactorily by aspirin-amphetamine compounds were failures on both new formulae, despite positive evidence of the amphetamine response. Some developed bizarre bleeding histories until they were reassured that the tablets contained no steroids. Several mistook the niacin blush for allergic hives. Responses varied from month to month with the subject's general physical and emotional stability. It is for this reason that statistics of our results are not appended here.

Inhibition of Ovulation

When inhibition of ovulation is desired, stilbestrol is least costly, although other natural and synthetic estrogens are equally effective in appropriate dose. Patients are started on the fourth day of the cycle on 0.001 Gm. daily. This is increased by one milligram daily on the 9th, 14th and 19th days, and discontinued on the 24th day.

Should breakthrough bleeding occur, the dose is immediately doubled for the balance of the cycle.

The newer 19-nor progestogens will also inhibit ovulation when taken from the 5th through the 25th day. Dosage varies from 5 to 10 mgs. twice daily, according to the patient's needs. In some subjects nausea will occur during treatment, or bleeding may begin should the patient omit a single dose during the course. Inhibition of ovulation, when done, should be continued for three to four months, and then discontinued. The diagnostic evaluation should be completed during this interval.

Despite the fact that primary dysmenorrhea occurs only in the presence of ovulation, and that the use of progesterone is seldom of benefit, there has been increasingly great success with the use of the newer progestational drugs. Norethynodrel and norethindrone have adequate inherent estrogen for effectiveness whereas the substituted progesterones needed supplemental estrogen. Norethandrolone has androgenic side effects in some subjects. Delalutin® was unsatisfactory here because of its indefinite end point.

In adequate dosage the progestogens are given from the 15th through the 25th day of the usual 28 day cycle, and are often highly successful even though ovulation is not inhibited. This suggests that inadequate endogenous progesterone may be causative. However, this does not account for those with dysmenorrhea and premenstrual acne cured of dysmenorrhea when their facial blemishes have disappeared or are satisfactorily covered.

Major Surgery III-Advised

Assuming satisfactory relief cannot be obtained (less than 10 per cent) examination under anesthesia, cervical dilatation and possible curettage, or even culdoscopy or exploratory colpotomy may be indicated in an attempt to find the true cause. Many recover with marriage, or after childbearing, and the cure remains as much an enigma as the original disease. Uterine suspension and pelvic neurectomy are mentioned only to be condemned. These may be indicated in treating endometriosis, but not in primary dysmenorrhea. Major pelvic surgery only leads to repeat operations as the second surgeon operates for "adhesions" or "cystic ovary." Reassurance and patient-physician rapport still remain the best method of treatment. Drugs are only temporizing, permitting the doctor to gain the full confidence of the patient.

Conclusions

Premenstrual tension and dysmenorrhea are specific yet ill-defined conditions affecting women

from early menarche to beyond the climacteric. Premenstrual tension in its broadest sense occurs in 70 per cent, but remains unrecognized by many a patient. However, her associates seldom miss the diagnosis. Although 75 per cent have symptoms of congestion, only 1 in 10 requires treatment. Approximately half have emotional disturbances, and one third require relief of pain. These subjects are in urgent need of assistance.

Education is required to overcome the resistance of the patients in accepting the condition and its treatment. Multidimensional rather than specific therapy is stressed as being most beneficial since dehydration does not give adequate relief. Education of the physician is also required, as good treatment is based on the understanding by the doctor of the patient's complex behavior at this time.

As in premenstrual tension, the treatment of dysmenorrhea is also based on understanding. The practitioner may give primary relief by inhibition of ovulation or by analgesic, antispasmodic or analeptic drugs while gaining the confidence of the patient. Secondary causes are ruled out by a complete and thorough physical examination. Improvement in general health is stressed, and conditions tending to aggravate the symptoms were pointed out that they might be avoided. These include violent exercise, prolonged standing, pelvic congestion, and emotional or nervous fatigue.

Basic treatment is outlined, and major surgery is mentioned only to be condemned. The value of the newer steroids is delineated, and their use in conjunction with other drugs is presented. Suggested dosage schedules are given.

Summary

The conditions called "premenstrual tension syndrome" and "primary dysmenorrhea" are briefly described and defined. Outlines of diagnostic procedures are given. Treatment is discussed. Physician-patient rapport is stressed in the management of both complexes, but the first phase of management remains recognition of the problem by both parties. The need for education which will enable the patient to receive treatment and the physician to give treatment is indicated. Charts^{††} outlining the results of treatment for PTS are given. No analysis of the results in dysmenorrhea is presented. Multidimensional therapy for PTS is stressed, and surgical treatment for dysmenorrhea is deplored.

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6-14 Omitted because of lack of space.

††Charts, statistical tables and notes of appreciation to drug manufacturers and associates omitted because of lack of space. All items omitted will be furnished by the author on request.

Association of Cervical Cancer with Circumcision of Sexual Partner

In a study of interviews with both cervical-cancer women patients and controls, we were unable to find an association between having the disease and reporting an uncircumcised husband. Dr. E. L. Wynder had previously reported an association in a study that also used data on circumcision history obtained from interviews with women patients. There may have been differences in asking the questions about circumcision but, if so, it is not clear how the data were affected.

An additional, independent, investigation of circumcision as an anatomical fact revealed that Jewish men probably have a maximum degree of anatomically complete circumcision, which occurs in less than half of non-Jewish men who consider themselves circumcised. The unique protection from cervical cancer that Jewish women enjoy is expressed in a risk ratio of a large magnitude, and this protection may be associated with maximum circumcision in their partners.

The circumcision study also revealed that one fourth to one third of men naturally may have a partially shortened foreskin, which is similar to that of some men who have been circumcised, but, in an interview study, many of them will be counted as uncircumcised. Consequently an interview study of non-Jewish subjects may fail to identify the fully circumcised and further dilute the results with many "partially circumcised" classified as uncircumcised.

A study by direct examination of men seems unavoidable.—John E. Dunn, Jr., and Philip Buell, Field Investigations and Demonstrations Branch, National Cancer Institute, Bethesda, Maryland, and California State Department of Public Health, Bureau of Chronic Diseases, Berkeley, California. *J. Nat. Cancer Inst.*, 22:749-764, 1959.

Thyroid Disorders

Maternal hypothyroidism is not commonly the cause of fetal hypothyroidism. Seventeen mothers of cretins were examined two months to 24 years after the birth of their last cretinous child; of these 12 were euthyroid, four were probably euthyroid and one was moderately but definitely hypothyroid.—E. A. Carr, Jr., M.D., et al., *Ann Arbor, Mich.: J. Clin. Endocrinol.*, 19:1, January 1959.

Dexamethasone — A Preliminary Clinical Study

IRA A. ABRAHAMSON, Jr., M.D., and IRA A. ABRAHAMSON, Sr., M.D.

MANY years of interest and experience in clinical research on adrenocortical steroids and their successful application in ophthalmology^{1,2,3} led us to evaluate a recently synthesized systemic corticosteroid, dexamethasone.* It is well known that the biologic properties of corticosteroids may be altered, both favorably and unfavorably, through changes in their basic structures. With the synthesis of dexamethasone, achieved by addition of a methyl radical at carbon 16 and a fluorine atom at carbon 9 of the prednisolone structure, the unending task of building better clinical properties into adrenocortical steroids appears to have moved an important step ahead.

According to initial studies with dexamethasone carried out by various investigators in other specialties — *e. g.*, rheumatology and dermatology — this compound appears to have a milligram activity approximately six times that of prednisone and prednisolone and 30 times that of cortisone;^{4,5} certain undesirable effects reported with the hydroxylated steroids, such as triamcinolone (muscle wasting, increased tendency to ecchymoses, abnormal weight loss, etc.), have not been associated with dexamethasone, and those seen with prednisone and prednisolone appear to be greatly decreased in incidence, at least with the short-term studies conducted to date. In fact, salt and water retention, diabetogenic activity and severe weight gain generally have been absent with dexamethasone.^{4,5,6}

Clinical Studies

In this preliminary report we shall describe our experience with dexamethasone in 28 patients with a variety of corticosteroid-responsive conditions. This group includes six cases of allergic blepharodermatitis, two herpes zoster ophthalmicus, 11 cases of uveitis (9 of iritis and/or iridocyclitis and two of chorioretinitis), two of macular edema, one retrobulbar neuritis, one thyrotropic exophthalmos and five surgical procedures (two corneal transplants, one acute secondary glaucoma due to lens protein induced uveitis and two cases of chronic iritis with cataract extraction). The ages of the patients ranged from 25 to 82 years.

Dexamethasone was prescribed in doses approximately one-sixth those of prednisone or

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prednisolone, in combination with other routinely employed therapeutic measures. The regimen instituted in almost all cases consisted of systemic use of dexamethasone, 0.75 to 1.5 mg. three times daily; when indicated, an antibiotic, such as Chloromycetin,[®] chlortetracycline or tetracycline, 500 mg. immediately and 250 mg. every six hours; and Diamox[®], 250 mg. twice a day (depending on the condition being treated). Local therapy consisted of the usual measures; *i. e.*, hot compresses, Metimyd[®] or Metretone[®] Suspension every two hours, and homatropine or pilocarpine solution as indicated. Patients were carefully followed for both therapeutic effects and possible steroid-induced secondary reactions.

While we realize that this series contains only a small number of cases, we have decided to make this preliminary report in view of the potential importance of dexamethasone to the ophthalmologic profession. A larger series is currently under study and will be reported on in the near future.

1. Allergic Blepharodermatitis

Six patients with allergic blepharodermatitis were given dexamethasone and local application of ice compresses. Several patients with seborrheic dermatitis of the lids in addition received Meti-Derm Ointment. All cases responded dramatically with almost total clearing in four days. No untoward effects were seen.

2. Herpes Zoster Ophthalmicus

Two patients, whose chief complaint was intense pain over the forehead and eye, were referred to us. Examination revealed vesicular formation

*Dexamethasone (Deronil[®]) used in this study was made available through the courtesy of Harry V. Pifer, Jr., M.D., Clinical Research Division, Schering Corporation, Bloomfield, N. J.

along the course of the ophthalmic branch of the fifth nerve. Herpes zoster ophthalmicus was diagnosed. Following local and systemic therapy, there was a noticeable amelioration of the pain and skin lesions.

3. Uveitis

A. *Iritis and/or iridocyclitis*: Nine cases of iritis and/or iridocyclitis were treated for periods ranging from two to four weeks. Antibiotics were given internally in all cases where a definite etiology could not be discovered. No side effects were seen in this group and the patients responded favorably.

B. *Chorioretinitis*: Two patients with chorioretinitis of unknown cause, one peripheral and one central, improved markedly on the previously outlined therapy. In the first case, vision improved from 20/200 to 20/30, with rapid healing of the lesions. In the other case, lesions underwent regression with pigment migration into the lesions, indicating process of healing. At present, the patients are off all medication and continue to do well. No side effects were noted. Although dosage must be individualized, 1.5 mg. three times a day for five to six days, followed by 0.75 mg. thrice daily, appears to be a good average dosage for dexamethasone in uveitis.

4. Macular Edema

Two patients with macular edema, one accompanied by angiospastic retinopathy, were treated with dexamethasone. In addition, one patient was given nicotinic acid, 50 mg. three times a day, and the other Diamox. Both cases improved satisfactorily with gradual lessening of edema, regression of lesions and amelioration of overall symptomatology. There were no untoward effects from the administration of the steroid.

5. Retrobulbar Neuritis

A patient with retrobulbar neuritis, cause unknown, resulting in sudden loss of vision (20/600) was treated with dexamethasone, nicotinic acid and tetracycline. At the end of three days, the patient's condition was markedly improved, with vision returning to 20/70 and lessening of the central scotoma. No side effects were noted.

6. Thyrotropic Exophthalmos

A patient with thyrotropic exophthalmos with chronic open angle glaucoma was treated with dexamethasone, Diamox, radioactive iodoine and topical pilocarpine 2 per cent four times a day. After two days, edema of the lids and face subsided greatly, and at the end of five days the patient showed marked improvement with minimal edema present. The patient continues to do

well on therapy. No adverse drug effects have been noted to date.

7. Surgical Procedures

A. *Corneal transplants*: Two patients with corneal transplants, one for corneal dystrophy and the other for corneal leukoma, were given dexamethasone to reduce postoperative reaction. The patient with corneal leukoma had a visual acuity of 20/400. Following a 6.5 mm. penetrating corneal transplant, she received systemic dexamethasone and Chloromycetin. Metimyd Ointment was instilled at each dressing and Metreton Suspension every three hours after the first 18 days. The result was dramatic, the graft remaining clear and the vision improving to 20/50 after three months' duration.

The patient with the corneal dystrophy had a preoperative visual acuity of light perception and projection. Following a 7 mm. penetrating corneal transplant, his postoperative care was similar to that of the previous case. The patient recovered satisfactorily with a finger counting at eight feet (partially reduced by the presence of a cataract). No untoward drug reaction was encountered in either case.

8. Acute Secondary Glaucoma

A patient with acute secondary glaucoma due to lens protein induced uveitis from a hypermature cortical cataract was treated with systemic dexamethasone, Diamox and Chloromycetin; local Metreton Suspension, homatropine 5 per cent, Neo-Synephrine® 10 per cent and hot compresses. Dramatic improvement, with clearing of the cornea and anterior chamber, occurred in three days. After six days, a successful intracapsular cataract extraction with complete iridectomy was performed. Postoperatively, dexamethasone dosage was gradually reduced and the patient continues to improve satisfactorily. No untoward drug reactions were seen.

Chronic Iritis with Cataract Extraction

Two patients with chronic iritis, accompanied by cataracta complicata, had remained quiescent on topical Metreton Suspension therapy. Both patients underwent uneventful intracapsular cataract extraction with peripheral iridectomies. For five days postoperatively, they received dexamethasone. No flare-ups of the iritis occurred and the patients recovered completely.

Discussion

Dexamethasone proved a highly effective corticosteroid in doses approximately one-sixth those generally used with prednisone and prednisolone. The lack of side effects was particularly gratifying with this agent. From this preliminary study it

appears that dexamethasone will prove a valuable tool in all steroid-responsive ocular conditions. It should also be borne in mind that healing following intraocular surgery is slowed by systemic corticosteroids; however, in spite of this apparent drawback we advocate their use for the first five or more postoperative days to prevent dangerous flare-ups of iridocyclitis, and thus speed recovery in the long run.

Summary

(1) Dexamethasone (Deronil®), a new adrenocortical steroid, was given to 28 patients with a variety of steroid-responsive ocular conditions.

(2) Dexamethasone proved effective in all 28 cases treated, in doses approximately one-sixth those generally used with prednisone and prednisolone.

(3) No steroid-induced side effects were observed during this preliminary study.

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Roentgenography of Portal Venous System

Percutaneous splenoportography was performed 40 times in 32 patients over a 15-month period. Successful venograms were obtained in 81 per cent and accurate splenic pulp pressures in 88 per cent of the patients. The procedure was informative 90 per cent of the time and in all but two patients. Significant intraperitoneal hemorrhage occurred twice, once requiring transfusion, but both times spontaneously ceasing.

The principal indications for this procedure are the detection and measurement of portal hypertension, preoperative selection of the proper venous shunt procedure, and postoperative evaluation of the patency and efficiency of the shunt. Other indications have been mentioned.

The authors have found percutaneous splenoportography combined with the measurement of splenic pulp pressure to be a safe, simple, and extremely useful procedure in evaluating the anatomy and function of the portal venous system.—Captain John E. Myers, Jr., M.C., U.S.A., and Colonel B. H. Sullivan, Jr., M. C., U. S. A.: *Medical Annals of the District of Columbia*, 28:181, April, 1959.

Factors Which Influence Mortality In Acute Myocardial Infarction

Factors influencing survival in a group of 318 cases of acute myocardial infarction were analyzed.

The mortality rate for the entire series was 41 per cent. Among the men it was 39.5 per cent; among women, 44.4 per cent. The mortality rate increased with the age of the patient. Twenty-six per cent of all deaths occurred within the first 24 hours, 44 per cent within 72 hours, and 71 per cent within the first week following hospital admission.

Increased mortality rate was associated with previous history of congestive failure, myocardial infarction, hypertension or cardiomegaly. As to circumstances immediately preceding an infarction, the only ones that seemed to be related to a high mortality rate were hemorrhage and the postoperative state. Not only the presence but the degree of shock, congestive failure, cyanosis and dyspnea adversely influenced chances for survival. Duration, location, radiation and number of attacks of pain did not appear to be associated with extraordinary mortality rates. Anterior was slightly more common than posterior infarctions, and the mortality rate was much higher. Thromboembolic complications and certain disorders of rhythm and of conduction definitely worsen prognosis.

Comparison of average mortality data as reported in different studies on acute myocardial infarction is improper and misleading because of the great differences between the kinds of patients included in various series reported upon. A standard method of grading the severity of acute myocardial infarction would help toward sounder comparisons.—Edward E. Harnagel, M.D., et al., Los Angeles: *California Med.*, 90:264, April, 1959.

Narcotic Antagonists

Nalorphine and levallorphan are specific and potent narcotic antagonists. Dramatic results are usually obtained within one to five minutes. If results are not obtained quickly, the physician should reconsider his diagnosis rather than repeat the antagonist. The antagonists are not effective against respiratory depression from causes other than narcotics. The actions of the usual analgesic doses of narcotics are antagonized by 5 to 10 mg. of nalorphine or 0.5 to 1.0 mg. of levallorphan given intravenously. Neither nalorphine or levallorphan induce or support narcotic addiction.—William T. Griffin, M.D., and Philip Hitchcock, M.D., Columbia, Mo.: *Missouri Med.*, 56:402, April, 1959.

Vaccine Therapy of Rheumatic Diseases

THEODORE A. WILLIS, M. D.

IN the voluminous contemporary discussions of rheumatic diseases one finds little, if any, mention of vaccine therapy. Two or three decades ago a comparable number of journal pages carried articles by rheumatologists of equal note reporting results of vaccine therapy as favorable as those presently attributed to the newer preparations. Recent writers recognize as temporary the responses to the newer products, report the more-than-occasional complications associated with them, stress the necessity of maintenance doses and admit that continuous administration of adrenal steroids is paralleled by progressive atrophy of these glands. It is written that in the long run the newer anti-rheumatic preparations are no more efficient than is aspirin.

Origin of Vaccine Therapy

Vaccines are still considered by some rheumatologists an important, even indispensable, part of their armamentarium, but it seems that in the haste to adopt the New, the Old has been neglected. Vaccine therapy of rheumatoid arthritis originated early in this century with the work of Wright,¹ Rosenow,² Crowe³ and others, reaching its greatest popularity in the late '20s and early '30s with a deluge of publications by many authors, prominent among whom were Burbank, Traut, Wetherby, Nichols, Clawson and Pemberton, who associated the disease with focal bacterial infections, particularly streptococcal.

Later, since bacteria could not regularly be demonstrated either in the blood or the involved joints, it was necessary to hypothecate, as the etiological factor, bacterial production of toxins having a predilection for joint tissues. The existence of toxins of both extra- and intracellular origin has since been proven: the former in the filtrate and the latter in the ground organisms of the same bacterial cultures.⁴ The two differ in biological effect, thus accounting for a difference between chemically killed and heat killed vaccines, as heat fractures the bacterial bodies. Metabolic toxic products may be formed in decomposition of proteins and, to less degree, of carbohydrates. These are ordinarily conjugated into harmless substances and excreted, but if oxidation of proteins occurs in this process before deamination, highly toxic substances having powerful pharmacologi-

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cal effect may be formed, some vasodilating, others vasoconstricting.

Methods of Using Vaccine

The first vaccines manufactured from focal infections were administered in progressively increasing amounts in order to induce severe local and systemic reactions which were expected to create immunity to specific bacteria and their toxins. Beneficial effects were ascribed to the ensuing febrile reactions and other heat producing agents were utilized, such as nonspecific vaccines, foreign proteins and even baking ovens.

Unfavorable complications including anaphylactic shock, neuritis, iritis and encephalitis soon discouraged these efforts and attempts to immunize arthritic patients by febrile shock were succeeded by efforts to desensitize them by minute carefully adjusted injections of autogenous or polyvalent stock vaccines prepared from focal infections. Serious reactions were thus avoided and more favorable results obtained.

Some critics of vaccine therapy have attributed favorable responses to vaccines used in this manner to the psychological effect of any therapeutic agent, and have reported comparable effects following injection of sterile water, saline or other innocuous substances.⁵ In discussions of placebos administered in various ills palliation is reported in from one third to two thirds of the patients treated.⁶ Psychology, however, does not account for variations in a patient's response to changes in the dosage of vaccine of which he is unaware. It is by such responses that each individual patient's optimum dose of vaccine is determined, a slight increase or decrease being followed by a corresponding variation in his response.

Etiology of Arthritis

Failure of antibiotics to relieve rheumatoid symptoms challenges focal infection as an impor-

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TABLE 1. Incidence and response to treatment in relation to sex.

Response*	Males		Females		Total	
	No.	%	No.	%	No.	%
0	10	5.6	23	7.2	33	6.6
1	52	27.9	104	32.4	156	31.2
2	88	49.1	151	47.0	239	47.8
3	29	16.2	43	13.4	72	14.4
	179	35.8	321	64.2	500	100.0

*Response to treatment is rated as 0 for no improvement, 1 for minor improvement, 2 for major improvement and 3 for complete relief of symptoms.

TABLE 2. Incidence and response to treatment in relation to type.

Response*	Rheumatoid		Osteo		Combined		Fibrositis	
	No.	%	No.	%	No.	%	No.	%
0	15	4.8	5	33.3	5	8.2	2	1.7
1	105	34.8	4	26.6	29	47.3	25	21.7
2	153	49.5	6	40.0	21	34.4	57	49.6
3	36	11.8	0	0.0	6	9.8	31	26.9
	309	61.8	15	3.1	61	12.2	115	23.0

*Response to treatment is rated as 0 for no improvement, 1 for minor improvement, 2 for major improvement and 3 for complete relief of symptoms.

TABLE 3. Incidence and response in relation to age.

Response*	0-20		21-30		31-40		41-50		51-60		61-70		71 plus	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
0	1	50.0	1	2.6	3	2.4	9	8.3	10	7.7	5	5.9	3	8.3
1	0	0.0	9	24.0	20	29.1	28	25.7	44	34.0	28	33.0	17	47.0
2	1	50.0	20	52.0	51	50.0	49	45.0	64	49.6	44	46.0	15	41.6
3	0	0.0	8	21.0	18	17.5	23	21.1	11	8.5	11	13.0	1	2.8
	2	0.4	38	7.6	102	20.4	109	21.8	129	25.8	84	16.8	36	7.2

*Response to treatment is rated as 0 for no improvement, 1 for minor improvement, 2 for major improvement and 3 for complete relief of symptoms.

tant etiological factor in the disease. Temporary amelioration following administration, or stimulation of production, of adrenal hormones suggests metabolic disturbance as a more probable cause. The adrenal gland is closely associated with emotional metabolic reactions. Physicians who treat rheumatoid patients know that their symptoms are often aggravated during emotional depression and tension.

The writer has so often seen arthritic joints of patients, who were progressing favorably, become swollen and painful after advent into the home of a critical, overly solicitous or dictatorial visitor that he has been tempted to dub the condition "Mother-in-law's Disease." Sometimes the reaction is in reverse. Rheumatic patients are frequently symptom free while on vacation, only to relapse when resuming the tensions of their routine activities. Congenial surroundings and emotional relaxation are more important in choosing a vacation spot than climate and mineral springs.

Stimulation of all body functions during pregnancy may well account for the frequent relief of joint complaints at that time, and improvement during congestive jaundice associates liver function with the disease. The liver is the great

detoxifying organ of the body. The writer has found indicanurea in 65 per cent of his arthritic patients. In the other 35 per cent, however, there is no deficiency of sulphuric acid detoxifying ability as they have demonstrated by strongly positive indican reactions after administration of small amounts of indole. Nor have they shown inefficiency of glycin or hippuric acid detoxifying functions.

Present Status of Vaccine Therapy

Vaccine therapy of rheumatoid arthritis has, regardless of many favorable reports following its use, fallen into such disrepute that national rheumatism societies have included it among those measures of little if any value. It has been said that there is neither clinical nor theoretical ground for the use of bacterial vaccine in rheumatic diseases. It is not included in a list of many anti-rheumatic therapeutic agents approved by the A. M. A. Council on Drugs, nor was it mentioned at the recent International Congress on Rheumatic Diseases (Toronto, June, 1957),⁷ where gold, corticotropin, prednisone, prednisolone, phenylbutazone, antimalarials and their various combinations were discussed, each by its proponent, who

noted the more regrettable complications of the others.

To exhume the corpus dilecti from beneath so authoritative and weighty a slab as this would seem a hopeless task, but in justice to the pioneers of vaccine therapy and to the many patients whose pain and disability can be relieved by it without danger of the complications of the newer drugs, the effort should be made, with a warning to anyone who might be interested, that vaccine therapy is not an indiscriminate "squirting of bug juice" but a meticulous adjustment of dosage of a proper product to each individual patient according to his reaction to the preceding dose. Otherwise the disconsolate opinion of the unbelievers will be confirmed.

Experimental Bacterial Production Of Arthritis

An extremely interesting association of bacterial infection with the pathological changes of rheumatoid arthritis has recently been reported from the department of agriculture of the University of Indiana where such lesions were produced in swine by injection of *Erysipelothrix rhusiopathiae*.⁸ Many of the experimental animals died of acute destructive purulent lesions of the liver, kidneys, and adrenals, associated with polyarthritic abscesses. Those that survived for several months developed chronic arthritis of the ankylosing type. In the chronic stage it was impossible to recover *E. rhus.* from the joints or blood of many of them. Whether the chronic joint pathology was due to the local effect of the acute sublethal infection or to loss of the protective function of the liver, kidneys or adrenals has not been determined. The writer obtained cultures of *E. rhus.* from these authors and after administering heat killed vaccine prepared from them is convinced that it is of some value in treating rheumatoid patients.

In 1924, Torry and Klein⁹ reported satisfactory response of arthritic patients to administration of Coley's toxins (Erysipelas and B. Prodigeosis) after removal of focal infections. They used the toxins, however, as fever producing agents, not for their specific erysipelas content.

Personal Experience with Vaccine

The writer, an orthopaedic surgeon, became interested in arthritis in a retrograde manner, first through physical and surgical correction of its deformities, then in their prevention and finally in treatment of the disease itself. During a visit to the Charterhouse Rheumatism Clinic of London he was impressed by the effects of vaccine therapy and since then has repeatedly compared its effects with those of the newer drugs as they were dis-

covered, noting the responses to changes in dosage, substitution of placebos, and deliberate psychological influence. He is convinced that there is definitely a psychological element in rheumatoid diseases; that aspirin and other salicylates are palliative; that though less dramatic in effect than the newer drugs and hormones, vaccine therapy meticulously administered is more efficient, more enduring in effect, and free from regrettable complications. He has concluded that an undetermined, but relatively small, percentage of individuals, either from heredity or unknown cause, are susceptible to presently unidentified metabolic or bacterial toxins which affect specialized connective tissues, giving rise to the changes of the rheumatic diseases. He is convinced that there is some unidentified factor in heat killed polyvalent streptococcus and micrococcus vaccine which, in minute doses, desensitizes patients to the toxins.

Basis of Report

In the series of 500 rheumatic patients presented here, first seen during the years 1952 and 1953, none had ill effect attributable to the vaccine other than temporary aggravation of joint pain while the dosage was being determined. When this was accomplished by decreasing the amount of vaccine when pain was aggravated, increasing it when there was no response and continuing it when pain was relieved, it was possible to lengthen the intervals between injections and finally, after three successive months without symptoms, to discontinue treatment of many of them for an indefinite time.

Classification of Rheumatic Diseases

For analysis the rheumatic diseases have been classified as rheumatoid arthritis, fibrositis, degenerative arthritis and combined arthritis. The last group is comprised of those patients who presented more than the degree of degenerative change consistent with their ages and also complained of pain and swelling of the joints. Joint degeneration is not an inflammatory lesion and should not be termed arthritis. Its pathological changes are associated with avascularity and calcification, not hyperemia. They regularly appear in skeletal structures in early middle life and are exaggerated by excessive mechanical and metabolic stresses.¹⁰ Pain appearing during the process is due to mechanical irritation of the aging tissues or to complicating arthritis.¹¹

Classed as fibrositis are those conditions variously named peri-arthritis, capsulitis, bursitis, tendinitis and epicondylitis, all characterized by inflammation of fibrous tissue occurring particularly

at its attachment to bone, in individuals of rheumatic tendency.

Response to Therapy

Of these 500 patients, 179 (35 per cent) were males, 321 (64 per cent) females. Three hundred nine (62 per cent) were diagnosed rheumatoid arthritis, 115 (23 per cent) fibrositis, 61 (12 per cent) combined and 15 (3 per cent) degenerative arthritis. They were divided into ten-year age groups, the greatest incidence being in the middle ages, particularly the fifties.

Response to treatment was estimated in four grades, 0 for no improvement, 1 for minor, 2 for major and 3 for complete relief of symptoms for at least three successive months. No sharp differential could be drawn between minor and major improvement. In the major group were listed those who continued to have occasional mild discomfort that did not interfere with normal activity; in the minor, those who were less definitely improved but able to continue employment under treatment. In the unimproved group were a number who discontinued treatment without a fair trial. Of the 500 patients, 6.6 per cent were unimproved, 31 per cent were somewhat improved, 47 per cent much improved and 15 per cent completely relieved. (v. tables 1, 2, and 3)

There was no significant difference in relation to sex but younger individuals responded more favorably than older. Victims of fibrositis progressed most favorably, then successively the rheumatoid arthritics, combined and degenerative arthritics. Improvement from vaccine therapy in the last group was attributed to relief of an unrecognized rheumatoid complication.

The influence of heredity in these patients was not carefully noted but it is the writer's impression that there is a definite familial tendency in the rheumatic diseases as noted by Stecher et al.¹²

The Preparation Employed

The vaccine used in this study, a heat killed polyvalent streptococcus and micrococcus product, was prepared in Leeds, England, under the direction of the Charterhouse Rheumatism Clinic of London (Crowe). The initial dose for each patient, arrived at after several years' experience, was 1250 bacteria. Ninety-four (18 per cent) of the patients responded favorably to this amount. For 227 (45 per cent) the dose was reduced, the least being 21 bacteria. For the remaining 179 (35 per cent) the amount was increased, the greatest being 3,200.

During the five years since these statistics were tabulated 66 of the patients have returned from

one to four times each with recurrences of symptoms and have responded to treatment in the same manner as originally, though requiring some variation of dosage. Others have continued to report at monthly or longer intervals because of symptoms or for prophylaxis.

Conclusion

An appalling number of discouraged and depressed individuals are told by their medical attendants that they have arthritis but that nothing can be promised them other than temporary relief from increasing doses of aspirin, or from hormones and drugs frequently associated with undesirable complications and which, if long continued, may leave them in even worse condition. This attitude on part of the medical profession is most unfortunate, particularly in respect to patients so susceptible to psychological impressions as are arthritics. Even if one attributes the sole benefit of vaccine therapy to its psychological effect, and the writer emphatically does not, as Traut and Passarelli have said in their discussion of placebos,¹² "The number of patients who improved justifies continuance of placebo administration."

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Present Status of Surgery for Rheumatic Valvular Disease

EARLE B. KAY, M. D., and H. A. ZIMMERMAN, M. D.

CONSIDERABLE progress has been made in the surgical treatment of acquired valvular disease since the advent of commissurotomy for mitral stenosis slightly over 10 years ago. The success of this procedure was so gratifying that many ingenious closed or blind techniques were devised for the correction of mitral regurgitation and aortic valvular lesions, the benefit from which was invariably transitory. It was apparent during this developmental phase of valvular surgery that further progress would come only when the heart could be opened, the valves adequately visualized, and the various pathologic features evaluated and corrected under direct vision. This necessarily had to await the development of a safe, efficient heart-lung machine and extracorporeal perfusion techniques to substitute for the heart and circulation during the surgical procedure.

Congenital lesions were the first to be corrected by open techniques. The majority of such defects involve the right side of the heart, the tissues involved are usually pliable, and the myocardial reserve for the most part is good. Experience gained in the management of extracorporeal circulation in congenital hearts was useful in the treatment of left sided acquired defects. However, many additional problems were introduced which required further study. In contradistinction to congenital lesions which involve stationary structures of the heart such as septa, chambers, and anomalous positions of vessels and openings, left sided defects involve moving structures of the cardiac mechanism—the proper opening and closing of valves in a high pressure system.

It further required working in many instances with severely diseased scarified and calcified tissues in patients with poor myocardial reserve from rheumatic involvement as well as chronic myocardial strain. Greater care had to be exerted in maintaining myocardial oxygenation to prevent cardiac arrhythmias, further failure, or areas of myocardial infarction postoperatively.

Much has been accomplished in the direct surgical treatment of acquired valvular lesions but many problems still exist, which are gradually being solved. This paper deals with the present status of the surgical correction of rheumatic valvular defects utilizing extracorporeal circulation and the problems still existing based on experience gained

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from operations in 60 patients with mitral or aortic valve disease.

Mitral Regurgitation

The results obtained to date in the surgical treatment of mitral regurgitation have been most gratifying and the future for the surgical therapy of this valve appears optimistic. Like all developmental phases, such techniques undergo modifications and improvements. The majority of patients with mitral regurgitation can now be greatly benefited by surgical correction and restored to a useful healthful life. The effectiveness of the correction is largely dependent upon the severity of the pathologic process and the degree of myocardial reserve.

Those patients with pure mitral regurgitation in whom there is adequate pliable valvular tissue with no loss of musculotendinous mechanism are ideal candidates for surgical correction. This type of valve represents 35 per cent of the entire series. The operative mortality in this group has been low (8 per cent) and the postoperative results good. The majority of patients with mixed mitral stenosis and regurgitation can also be helped. Patients with severely scarred, contracted, matted, and fused cusps, chordae tendinae and papillary muscles in which there is loss of the valvular mechanism or whose valves are densely calcified present the most difficult problems in repair. Short of partial or complete valve replacement, such deformities cannot be adequately corrected in most instances. Such patients comprise the majority of failures. Fortunately, this type of destroyed valve does not comprise over 15 per cent of those encountered.

Technique of Repair

The surgical technique employed in the correction of mitral regurgitation is varied, dependent upon the presenting pathologic features. The details of such techniques have been published else-

where^{1,2,3} and will not be repeated in detail. Patients with pure mitral regurgitation in whom the valve cusps and musculotendinous mechanism are good, and in whom the regurgitation is due primarily to a dilated annulus with separation of the valve cusps as well as some loss of valvular substance, can be effectively corrected by means of annular plication. Valves in patients with mitral stenosis and mitral regurgitation can, for the most part, be effectively corrected first by increasing the size of the orifice by commissurotomy, next by regaining valve mobility by freeing the matted and fused cusps, chordae tendinae, and papillary muscles, and last by correcting the insufficiency either by annular plication or by addition of valvular tissue in the form of plastic material. The destroyed valve necessitates valvular excision and replacement by partial or complete prosthesis. There is considerable room for improvement in this latter technique, but great strides are being made.

Results

There has been an overall mortality of 23 per cent in the first 42 patients operated upon. The developmental phase of a new operative technique was undoubtedly responsible for some of this mortality rate. Three patients died from air embolism. With greater experience and refinements in techniques the foregoing causes of failure can largely be eliminated. The two main causes of death were myocardial failure in the poor risk patient with poor myocardial reserve and insufficient improvement in patients with destroyed valves in whom adequate correction was not obtained. Both of these factors in the future will undoubtedly be eliminated. Since there is now a suitable technique for surgical correction of mitral regurgitation such patients will be seen at an earlier stage in their disability. Also, with further progress in the development of valvular prosthesis greater correction will be afforded patients with destroyed valves in the future.

The marked improvement in left atrial pressures following correction of the insufficiency, the reduction in heart size, and relief of symptoms all point to the successful correction of the defect. It is still too early to discuss the late results, since such operations have been done only in the past two years. Sufficient time has elapsed, however, to demonstrate that greater improvement has been afforded the more recent patients who have had the benefit of the refinements in the operative technique.

Two complications have occurred postoperatively in approximately 15 per cent of the patients. There has been a recurrence of the murmur in a few of the early patients operated upon in whom

it was felt that the sutures had pulled out. Since re-enforcing the sutures so that the tension is against incorporated sections of ivalon, this complication appears to have been eliminated. The other complication is a febrile episode due either to a subacute bacterial endocarditis (all blood cultures have been negative) or to an exacerbation of rheumatic activity which may have altered what appeared initially to be a good result. This has led to the use of larger dosages of broad spectrum antibiotics for a longer period during the patient's convalescence with what appears to be a satisfactory reduction in the frequency of such episodes. This syndrome is also found following the "closed commissurotomy" technique for mitral stenosis.

Mitral Stenosis

Good results from mitral commissurotomy have been reported in 50 to 75 per cent of the patients so treated. This improvement has also been maintained in approximately 50 per cent of the patients so treated up to five years time. These data coupled with the low operative mortality for the closed method of commissurotomy present a fairly optimistic impression of the surgical treatment of mitral stenosis. Such series of patients, however, for the most part did not include all patients with highly calcified valves for whom nothing could be done, those patients who were found to have associated mitral regurgitation, or those with a highly clotted auricle in whom the surgeon did not choose to continue the procedure for fear of increasing the incompetence, or of producing embolization.

In addition to this, there has been an increasing number of recent reports concerning re-stenosis of the valve in 10 to 20 per cent of the patients occurring within several years of the operative procedure. Re-activation of the rheumatic process undoubtedly accounts for some of the re-stenosis but probably not over five per cent. The opinion of most cardiac surgeons is that the valve was incompletely opened at the time of the initial operation. Furthermore, it was the considered opinion of at least half of the cardiac surgeons in a recent poll⁴ that they were not completely satisfied with what was accomplished with the closed technique in the treatment of mitral stenosis in over 50 per cent of such patients. This correlates closely with our experience.

Consequently, for the past year and a half, we have adopted the policy in patients with mitral stenosis to have the pump oxygenator available. In the event the valve cannot be adequately opened by the closed technique, in the presence of a clotted auricle, a highly calcified valve, or associated regurgitation, the necessary cannulations

are made and the surgical correction performed under direct vision through the open heart. It is felt that by following such a policy we have considerably extended the number of patients to be benefited as well as the degree of benefit afforded each patient.

There are additional advantages in having available the pump-oxygenator and extracorporeal perfusion. It has enabled us to support the circulation while performing the commissurotomy in those patients in whom the operative procedure would have been discontinued or incomplete because of hypotension, cardiac arrhythmias, or an occasional arrest. The support of the heart and circulation by the machine has enabled us to persist in our efforts in the various maneuvers necessary to obtain the desired results. As a whole it has been felt that a greater increase in the size of the mitral orifice has been attained as well as greater mobility between the cusps and the chordae tendinae. All patients who are reoperated upon for their mitral stenosis are routinely done by the open technique.

As a consequence of the preceding policy, at least 85 per cent of the patients with mitral stenosis have as complete an operation as possible, as compared to less than 50 per cent previously by the closed technique. This has reflected itself in greater clinical improvement as well as a higher incidence of patients with essentially normal heart sounds postoperatively.

As in mitral regurgitation about 15 per cent of the valves are so severely destroyed that without valve replacement only partial benefit can be obtained. The foregoing policy has lowered the operative mortality for the closed commissurotomy technique to approximately one per cent as a result of shifting the bad risk patient to the open technique group. Obviously the operative mortality in this latter group is higher—approximately 18 per cent—but one must remember that these patients might be referred to as the salvage group that would not have been benefited previously. In our opinion the closed and the direct vision techniques employing a pump oxygenator should not be considered as competing techniques, but instead as supplementary techniques, each of which is to be used where indicated to improve the overall results in the surgical correction of mitral stenosis.

Aortic Stenosis

The surgical relief of aortic stenosis by closed techniques has been discouraging in the past not only from the high operative mortality but from failure of obtaining satisfactory improvement in the majority of patients. The best results, of course, have been in patients with fibrous stenosis.

However, as one might anticipate, blind dilating techniques are not selective as to the aortic commissures but as often as not would tear the cusps producing uncontrollable regurgitation or embolization. It was also virtually impossible to obtain a functioning valve in one that was highly calcified even though the operator was fortunate enough to crack the calcium. More often than not such tears occurred in the valve cusp about the calcium and not at the commissures. Even though the commissures were partially opened, the mass of calcium still acted as an obstructing agent.

The advantage of the open technique is that the degree and location of the pathologic aspects of the valve can be visualized and selective correction employed. Excellent results are obtained in the patient having only fibrous stenosis where the commissures can be easily and quickly opened. In patients with valves highly calcified, all or a portion of this calcium can be removed, relieving this as an obstructive agent. In the presence of associated regurgitation, or in the advent of causing it, measures can be employed in its relief. As with the mitral valve, a certain number will be so highly destroyed that nothing short of complete valve replacement will suffice.

Good operative results in aortic stenosis, however, are generally confined to the patients having fibrous stenosis with otherwise fairly good valve tissue which can be corrected fairly readily by selective commissurotomy utilizing the open technique with temporary cardiac arrest. If more than 20 to 30 minutes of cardiac arrest is required for the procedure, difficulty in restarting the heart, cardiac arrhythmias, and later cardiac failure or arrest may ensue as a result of the hypertrophied left ventricle tolerating poorly this period of myocardial anoxia. In patients requiring longer periods of definitive surgery, myocardial oxygenation by means of direct coronary artery perfusion should be employed.

If the valve is highly destroyed by calcium or associated with regurgitation, as has been encountered in approximately 50 per cent of such cases, the operative correction without partial or complete valvular substitution has in our hands been disappointing. Occasionally excellent and very gratifying results have been obtained but not with the same degree of success or regularity as seen in the mitral valve. Frequently, those patients with highly calcified valves can be detected in advance by means of Bucky films or fluoroscopically under the image amplifier.

It is our impression that with the tremendous strides being made in aortic valve surgery and with the use of prosthesis, that patients with calcified aortic stenosis, unless doing poorly, should

await further advances. Though the surgeon in many instances may have a very successful result, surgical intervention, in our opinion, should be temporarily delayed until the proper techniques have been developed to correct any contingency that might be unexpectedly encountered.

Aortic Regurgitation

Some patients with aortic regurgitation have had partial improvement with the use of the Hufnagel valve placed in the descending thoracic aorta. The improvement, however, is only partial and frequently is just temporary. At best it gives only partial benefit. It is of no value in the large group of patients with a combination of stenosis and regurgitation. Much has been accomplished in the open techniques using the pump oxygenator, but the progress in aortic valve surgery has lagged behind mitral valve surgery, even though occasional very spectacular results have been obtained.

The problem presented in patients with pure aortic regurgitation differs considerably from that noted in pure mitral regurgitation. The cusps are usually small and atrophic and the free edge tends to herniate into the ventricle. A good result may be obtained by commissure fixation of the free edge at a higher level in the aorta and the addition of a valvular substance in the form of plastic material. However, it is felt that a better result could be obtained in many instances by complete valvular replacement.

Similar views are held in regard to the highly destroyed calcified regurgitant valve, in that again occasional very gratifying results are obtained by excision of the calcified valve and replacement by plastic cusps now available. Whereas probably not over 15 per cent of mitral valve lesions will require partial or complete prosthetic replacement, it is our opinion that closer to 50 per cent of aortic valvular lesions will require partial or complete valvular replacement if one strives and hopes to attain the same degree of hemodynamic improvement. Tremendous strides are being made in such prosthetic valves and cusps which will be superior to those now in use. Furthermore, the use of direct coronary artery perfusion to maintain a beating, well oxygenated myocardium now allows sufficient time for a more definitive correction of such defects. Consequently at the present we prefer, if the patient's condition otherwise permits, to temporarily withhold surgical correction in such instances until further improvements in these techniques are forthcoming.

Summary

Considerable progress has been made in the past few years in the surgical correction of ac-

quired valvular disease with the use of the open heart techniques made available by the development of heart-lung machines and extracorporeal circulation. The results of the surgical correction of mitral insufficiency have been most gratifying, in that the majority of such patients can be restored to a healthful life. In the near future the small group remaining unbenefited will also be helped with the further progress being made in partial and complete valve prosthesis.

The availability of the heart-lung machine and direct vision techniques have supplemented the closed commissurotomy technique for use in the complicated case and has extended considerably the number of patients with mitral stenosis now helped by operation. Though aortic valve surgery is not done with the same degree of consistent success as mitral valve surgery, great strides have and are being made in this field so that even now results have been attained which will be even further improved in the very near future.

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Views on the Treatment of Thyroid Conditions (Other Than Cancer)

In general, small non-toxic adenomatous goitres should be removed because of the possible presence of an occult carcinoma. In older persons, particularly with multiple soft nodules, the goitre may be left alone with reasonable safety. Large non-toxic nodular goitres should be removed.

The treatment of choice of nodular goitre with hyperthyroidism is thyroidectomy. Exophthalmic goitre may be treated by antithyroid drugs, radioiodine or thyroidectomy. The antithyroid drugs are rarely used at present as definitive treatment, but they have some value in pre-operative preparation.

Radioiodide is the agent of choice in older persons, while thyroidectomy is indicated in younger persons, particularly in women of child-bearing age and during pregnancy. Hashimoto's thyroiditis and colloid goitre should be treated with desiccated thyroid, granulomatous thyroiditis with adrenal steroids, and Riedel's thyroiditis by means of "partial" thyroidectomy.—B. Marden Black, M. D., Rochester, Minn.: *Proc. Roy. Soc. Med.*, 52:167, March, 1959.

Torsion of the Fallopian Tube and Ovary

Report of a Case

JUAN CARLOS RUIZ BUENO, M.D.

TORSION of the fallopian tube and ovary is an uncommon condition which, in spite of the seriousness of the disease, is not diagnosed correctly in most instances and is often overlooked as an acute surgical emergency.

Several reports have been published since 1890, when Bland-Sutton, cited by Kohl¹ and Sandler,² described the first case of tubal torsion.

In reviewing the literature, we found, according to R. J. Crossen, that anything which increases the weight of the adnexa may produce torsion. Among the most frequent pathologic lesions considered as causative factors have been mentioned: pseudomucinous cystadenomas, serous cystadenomas, dermoids and fibroids (Kelberg and Randall³); hydrosalpinx (Shaw). Regard, in his series, also found infection, tumor and ectopic pregnancy. There are several reports of torsion complicating pregnancy (Savage in 1936, Caldwell in 1949, Kushner & Rosenbeum in 1952, and Robins⁴ in 1954). Peer-man & William⁵ reported several cases in 1954, one of which had no associated pathology. Recent reports have been published in which torsion of the adnexa followed a Pomeroy sterilization (Kohl¹ in 1956 and Sandler² in 1958).

Symptomatology and Physical Findings

There are no pathognomonic symptoms or signs of tubal torsion. The great majority of patients, however, complain of colicky pain of sudden onset in either of the lower quadrants, sometimes with radiation to the flank, groin or lateral aspect of the thigh (Kohl¹). The pain may vary between dull, sharp, and dull with sharp exacerbation. Nausea and vomiting form part of the symptom-complex. Urinary frequency, dysuria and painful defecation are seldom present. The temperature may be slightly elevated with moderate increase in the pulse rate.

The patient is usually restless and anxious, but shock is not commonly observed. The abdomen is distended and at times frank rebound tenderness is detected with guarding of the abdominal muscles and muscle spasm. Pelvic examination reveals a tender mass in the affected side. The white

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blood cell count shows moderate leukocytosis, usually not over 20,000/cu. mm. Urinalysis and x-ray are not of significance but such procedures as cul-de-sac puncture, intravenous pyelogram, cystoscopy, frog test, etc., can be of great value in differentiating this from other diseases.

Treatment in most instances is salpingo-oophorectomy and occasionally total abdominal hysterectomy.

Case Report

The patient, a 34 year old white married woman, gravida II, Para II—youngest child 5 years old—was admitted to Bethesda Hospital on July 3, 1958, with chief complaint of severe abdominal pain in the right lower quadrant associated with vomiting and uterine bleeding. Menses began at 10 years of age. Menstrual periods were more or less regular. No dysmenorrhea. Flow was normal up to five months prior to admission when it became heavier and prolonged, lasting from 7 to 10 days. Her past history was negative for chronic illnesses. She had had appendectomy and hemorrhoidectomy several years ago. Allergies negative.

About a month before admission, the patient experienced moderate pain in the lower abdomen. One week later, pelvic examination showed a small fibroid of the uterus; the adnexas areas seemed clear. On her expected day of menstruation, the patient awakened with cramp-like pain in the right lower quadrant, accompanied by a heavy blood flow. She was brought to the hospital emergency room when the pain increased in severity and spread to involve the entire abdomen.

The abdominal examination at this time showed generalized tenderness with greater intensity in the right lower quadrant; moderate muscle rigidity over this area was noted, no rebound tenderness. The pelvic examination revealed a tender mass involving the uterus, which was enlarged to approximately the size of a three month pregnancy, irregular in shape, retroverted, with an orange-size nodule on the anterior right wall, quite tender on motion. A diagnosis of fibromyomata uteri or possible adenomyoma was made. Several laboratory examinations were carried out and the patient was admitted for further evaluation and possible total abdominal hysterectomy.

The physical examination revealed a well developed, well nourished woman in a great deal of distress. Lungs and heart were within normal limits. Abdominal and pelvic examinations were as previously described. Temperature, rectal, 99°; pulse rate, 88 per minute; respira-

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tions 20/min.; blood pressure 110/56. Red blood cell count 3,480,000/cu. mm.; hemoglobin 10.5 Gm.; white blood cell count 8,550/cu. mm.; differential: neutrophils 73, band forms 3, lymphocytes 19, monocytes 4, eosinophils 2. Kahn serologic test for syphilis, negative. VDRL nonreactive. Urinalysis negative. Blood type O, Rh positive. Chest x-ray normal; barium enema negative; intravenous pyelogram reported a soft tissue mass in the pelvis producing some distention of the right ureter and kidney pelvis.

Operation: In the operating room and under anesthesia, the uterus could not be well outlined. There was a fairly solid mass that completely filled the pelvis and extended almost to the level of the umbilicus. Cervix was clean. Because of a relaxed pelvic floor associated with moderate rectocele, a dilatation and curettage followed by posterior colporrhaphy preceded the laparotomy.

On entering the abdominal cavity, it was seen that the previously mentioned mass was a huge laminated blood clot extending to the umbilicus. This mass was removed in pieces and it was found that the source of the bleeding was a twisted tubo-ovarian mass on the right side. This mass was completely necrotic, making it impossible to determine the original pathology, but there was a marked torsion of the tube, ovarian suspensory ligament and pelvic ligaments. A right salpingo-oophorectomy was performed with dissection of the tubo-ovarian mass up to the cornu of the uterus. The uterus, left tube and left ovary were normal in appearance.

The patient had an uneventful postoperative course and was discharged on her ninth postoperative day.

The pathologic report was as follows: Large mass of clotted blood and fibrous tissue intermixed, much of it being a dark red, spongy material covered by a glistening red-grey membrane. The fragmented pieces of dark red tissue appeared to have been involved in a cystic process. The mass weighed 550 grams. The microscopic view showed blood in distended vessels and in fibrous tissue. Some of the fibrous tissue appeared well organized as fairly densely distributed spindle shaped cells in interlacing bundles. Result: Fibrous tissue with infarction.

Our final diagnosis was torsion and strangulation of tubo-ovarian mass of unknown type.

Summary

1. A case of torsion of the fallopian tube and ovary is presented.
2. The most common etiological factors, as well as the more outstanding symptoms and laboratory examinations have been reviewed.
3. It is pointed out that, although torsion of the fallopian tube and ovary is not a common condition, it should be suspected whenever the mentioned symptoms and signs are present.
4. Treatment in most instances is salpingo-oophorectomy. However, in certain situations, total abdominal hysterectomy is indicated.

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Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEPPFEL, M. D.

Columbus, Ohio, Chairman

Following is the summary of a case which was discussed before the Franklin County Pelvic Cancer Delay Committee on May 20, 1959, at its regular monthly meeting held at the University Health Center.

Case No. 70. The patient is a 73 year old white woman who was first seen at University Hospital in 1953. She was aged 67 at prior admission. At that hospitalization a cervical amputation, uterine interposition operation and an anteroposterior vaginal repair was carried out.

Five months prior to present admission the patient began to have vaginal bleeding. She was seen one week prior to admission and advised to come in for diagnostic dilatation and curettage.

Adenocarcinoma of the endometrium was found uncurettage.

Comments

DR. HOLLENBECK: I do not believe that there is a place for interposition operation in a 67 year old woman. One simply leaves a potentially dangerous organ and most certainly this was so in this case. Surgery for prolapse in the elderly individual is vaginal hysterectomy with proper resupport.

DR. EZELL: We are now faced with two difficulties: (1) The implantation of radioactive material into a uterus which has been interposed directly beneath the bladder. Because of the close proximity of bladder we are limited in the amount of irradiation that can be delivered preoperatively. (2) The surgical approach is complicated because of pre-existing surgical scarring.

DR. POMEROY: The irradiation hazard is certainly greater for this individual.

DR. HOLZAEPPFEL: Under the circumstances, we must charge the delay to the medical profession. *Physician delay*, 60 months. This indeed represents an unfortunate series of events.

Management of Varicose Veins During Pregnancy

Varicose veins during pregnancy are managed conservatively with adequate elastic support until after delivery, when a complete stripping operation can be thoroughly and safely performed. This extensive, elective surgical procedure is done preferably when the patient is not pregnant, because a major surgical procedure should not be done upon a pregnant patient except as an emergency. —Karl A. Lofgren, M.D., Rochester, Minn.: *Minnesota Med.*, 42:409, April, 1959.

Keratoconus

A Case Report on Preventable Blindness

WILLIAM H. HAVENER, M. D.

A BLIND EYE is a serious loss to both patient and community. Awareness of the preventable nature of a significant portion of this blindness should help in reducing the incidence of such tragedies. The representative cases to be presented here are selected to emphasize relatively common causes of blindness which can in many instances be averted by proper, timely care.

Case Report

Progressive blurring of vision in left eye was first noted by this girl at the age of 16. Astigmatic correction with regular glasses was initially effective, but during the following three years astigmatism increased and became irregular so that even with glasses vision was less than 20/200. The right eye followed a similar course, beginning a little later.

Examination showed the eyes to be perfectly normal except for a marked conical distortion of the apex of the cornea. This was best appreciated by having the patient look down and observing from above the sharp curvature of the lower lid as it lay against the cornea. In the more advanced left eye a faint grey opacity was barely visible at the apex of the cone. Contact lenses were fitted, and improved vision to 20/20 O. D. and 20/30 O. S.

Discussion

Keratoconus is an uncommon degenerative corneal disease which usually first appears in young adult life. It consists of a progressive thinning of the central cornea, which then protrudes forward in a conical distortion. Astigmatism becomes very pronounced. More severe cases develop central corneal scarring. Rupture of the cornea is rare, and usually requires some minor trauma as the precipitating event. Spontaneous arrest of corneal degeneration ordinarily occurs after some years, but existing damage is irreversible. Most keratoconus is bilateral, but often the two eyes are quite unequally affected. The etiology is completely unknown.

Modern methods of treatment of keratoconus include use of scleral contact lenses and corneal transplantation. Contact lenses are practically mandatory for the patient with moderately severe keratoconus since in no other way can his vision be corrected. Optically, the irregular corneal surface is eliminated by the fluid under the contact lens, and the perfectly ground lens becomes the front refracting surface of the eye. Very careful fitting is necessary to avoid corneal-lens contact, which may be quite irritating. (The scleral type contact lenses rest on the sclera. Corneal lenses float on the precorneal tear film, and are very difficult or impossible to fit to the distorted keratoconus contours).

Corneal transplantation is a fairly successful

The Author

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method of restoring vision to cases of advanced keratoconus. Scarring or extreme surface distortion precludes the use of contact lenses and forces the patient to have surgery if he wishes useful vision. Transplantation is a delicate and uncertain operation, requiring several weeks of hospitalization, and three months of limited activity post-operatively. Unfortunately, only about one-third of patients will achieve 20/30 or better vision with corneal transplantation. Another third will see 20/200 or better. A second operation may be done and is often successful.

Little over two decades ago, keratoconus was practically an untreatable cause of visual loss. The remarkable progress made in contact lens technology and advances in corneal surgery have given us two effective methods of restoring vision to these patients.

Treatment of Hypertension Requires Perseverance

Never before has the medical profession been in such an advantageous position for constructive accomplishment in the treatment of hypertension. Successful management, however, requires considerable thoroughness and perseverance. To the physician who applies this newer knowledge wisely the satisfactions fully justify the effort expended. When the profession as a whole approaches the task of managing an elevated blood pressure with the same positivity that they approach the problem of managing an elevated blood sugar, the ravages of uncontrolled hypertension may well become greatly alleviated.—Edward D. Freis, M. D., Washington, D. C.: *Southern M. J.*, 51:1281, October, 1958.



MATERNAL HEALTH IN OHIO

Case No. 304

This 29 year old white woman, gravida IV, Para III, expired *undelivered* at 37 weeks. She had had rheumatic heart disease (mitral stenosis) "for years." No failure listed. Three previous pregnancies were delivered vaginally at 36 weeks— (1) at 16 years of age, fetal death; (2) at 19 years of age, live birth; (3) at 21 years of age, live birth—no other complications listed. Last menstrual period was December 7.

The patient was first seen at eight weeks gestation when she was found to have rheumatic heart disease, mitral stenosis (compensated); no difficulty listed during the prenatal course until 36-37 weeks. Her blood pressure ranged from 130/90 to 120/70; weight gain 9½ pounds; urine negative; she was seen frequently by the attending physician. At 36-37 weeks gestation she developed a cough, first noted upon assuming the recumbent position. This persisted for four days. During this time she continued to carry on her own housework.

The day prior to admission to the hospital emergency room, the patient was shopping downtown. She entered the hospital emergency 12:50 a.m., August 25, with acute pulmonary edema, and edema of feet and legs. Emergency treatment was given, including atropine gr. 1/75 intravenously; pressure O₂; Cedilanid® digitalizing dose intravenously. Cardiac consultation was obtained, but patient expired undelivered at 3:30 a.m., August 25, two hours and 40 minutes after admission. A post-mortem cesarean section was done, delivering a stillborn fetus. There was no autopsy.

Cause of Death: Acute pulmonary edema due to heart failure, rheumatic heart disease with mitral stenosis; Utero-gestation 37 weeks.

Comment

The Committee voted this a preventable maternal death, with bilateral responsibility on both personnel and patient. It was felt that the patient should have been seen early in the pregnancy by the cardiologist. The Committee also observed the "cough sign" was present four days before any treatment and hospitalization was prescribed. At the time of the maximum load on the heart, the patient experienced heart failure. This was rather characteristic; the Committee felt hospitalization should have been ordered at least four days prior to the date of the emergency treatment.

Case No. 193

This 33 year old white woman, gravida V, Para IV, expired at term *undelivered*. The history and record available on this patient was very scanty. In 1951 a nervous breakdown was incurred. In 1953 she was treated for anemia. Unfortunately, the past obstetrical and present prenatal records were lacking. The patient stated she was unable to contact her obstetrician for six weeks, and when seen by another physician, near term.

TOPIC THIS MONTH:

Maternal Death* Involving Heart Disease

she presented edema of the lower extremities and abdomen. Treatment (no detail) was given and on August 8 labor ensued at term.

Upon admission to the hospital the patient was in extremis, with congestive heart failure, pulmonary edema; both medical and obstetrical consultations were held. Admitted at 5:50 p.m., August 8, she expired at 9:10 p.m. the same day in early labor, undelivered. A postmortem Cesarean section was carried out immediately. A stillborn infant 6 pounds and 13 ounces was delivered. Autopsy permission was granted.

Pathological Diagnosis: Cardiac hypertrophy; non-deforming rheumatic mitral and aortic valvulitis; arteriosclerosis (a) aorta moderate, (b) coronary moderate, pulmonary edema (marked); pleural effusion 100 cc. left; chronic passive hyperemia of lungs.

Comment

The Committee voted this a preventable maternal death, with responsibility bilaterally placed upon both personnel and patient. Inadequate information in this case was suggestive of insufficient preparation for labor. No information was available surrounding the major part of the prenatal care. The question arose—"Should such a patient be advised to conceive in view of her heart disease?" Certainly the information available could throw little light on this question, and others which arose during the Committee's discussion.

Case No. 274

This 30 year old white woman, gravida III, Para II, expired *undelivered* at 36 weeks' gestation. The patient had had rheumatic heart disease for several years. Since October, 1952, she had "been on digitalis, bed rest, and diuretics" until death. Pneumonia had been incurred several times between her pregnancies. It was thought the rheumatic heart disease was manifested by an aortic and mitral valvulitis. Decompensation had been present

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by official representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

for four and one-half years. The two previous pregnancies, 1952 and 1954, were delivered vaginally at 38 weeks gestation, with success.

During this present pregnancy, the patient was hospitalized for three weeks at 24 weeks of gestation. Then weeks 27 to 30 were spent at complete bed rest at home, with full-time help. Two physicians were on this case, an internist and another in charge of the pregnancy. Visits were made every *two* weeks. Some edema was present from the onset of the pregnancy. At noon, April 25 (36 weeks) dyspnea developed and patient was admitted to the hospital at 5:30 p.m. Her course was downhill; all measures to combat cardiac failure were unsuccessful, and the patient expired 12 hours later (not in labor), undelivered. Postmortem section was carried out promptly and the infant survived one hour. Autopsy permission was not granted.

Cause of Death: (1) Cardiac failure; (2) rheumatic heart disease; (3) gestation, uterine 36 weeks.

Comment

The Committee voted this a maternal death, nonpreventable. Members noted the record did not mention any instructions given the patient prior to her last pregnancy. No doubt her physician had discussed the seriousness of another pregnancy with her, in the light of the depleted cardiac reserve. Although specific details in treatment were lacking, it appeared that medical management of the cardiac angle was adequate.

The collateral aspects of infant survival in cases 304, 193 and 274 have been discussed previously in this column, "Maternal Deaths With Postmortem Cesarean Section" (25 cases), *Ohio State Medical Journal*, 54:1315-1317, Oct., 1958.

Comment of Consultant

The following comment of a consultant, who is a specialist in Cardiology, was given at the request of the Committee.

Case No. 193: I am a little puzzled by the autopsy description of cardiac hypertrophy but nondeforming rheumatic mitral and aortic valvulitis. Arteriosclerosis of the coronary vessels was moderate. I am not exactly sure what type of heart disease the patient had, as coronary disease is extremely uncommon in women of the age group to become pregnant. I wonder if she didn't actually have rheumatic heart disease with deformed aortic and mitral valves.

I would say this was a preventable death but would place the burden equally, both on the patient who spent six unsuccessful weeks trying to contact her obstetrician, and also on the obstetrician for leaving a cardiac patient unsupervised for such a long period. I also would think that when she presented edema of the lower extremities and abdomen when seen by another physician shortly before term she should have been immediately hospitalized. This could have been done and vigorous therapy for congestive heart failure begun. This might have altered the outcome. Obviously it was too late the day she was

admitted to alter the course much with less than four hours to work on. The case points up the necessity for close cooperation between the obstetrician and internist when patient has pregnancy and heart disease. Such cooperation might well have saved this woman.

Case No. 274: I am not certain that this was a nonpreventable death. This patient had had rheumatic heart disease for years. She had been in heart failure apparently since October of 1952 inasmuch as she had been on digitalis, bedrest and diuretics. A cardiac patient who is pregnant but who has been in heart *failure* when in a non-pregnant state in my mind should have a therapeutic abortion as soon as the pregnancy is discovered. This is a very serious situation and can lead to a fatal outcome such as this. The episodes of pneumonia could have been pulmonary infarction which occurred between her pregnancies.

If need be I would say that this patient should have stayed in the hospital from 24 weeks on, to term. I am not certain that a visit by the internist every *two weeks* is sufficiently close observation of a woman at one of her peak loads who has been in heart failure in the nonpregnant state. Had she been hospitalized during this period of time the outcome might have been different. Myocardial insufficiency might have been detected earlier than it was at 36 weeks when dyspnea developed and more drastic measures might well have been possible to save the mother and possibly the child. Again I think the cooperation between the two physicians was not close enough for this particular situation. Therefore, I cannot be sure the medical management of the cardiac angle was adequate.

Case No. 304: This case differs slightly from the preceding case since there is no mention of heart failure in the nonpregnant state. I would agree that the death was possibly preventable in that when the cough first developed this patient should have been hospitalized. Her weight gain was not excessive. She should not have been permitted to carry on her household work or be downtown shopping.

The only criticism I would have in the emergency treatment for pulmonary edema is the lack of a phlebotomy. This at times can be lifesaving. Bedrest plus adequate digitalization and sodium restriction might well have saved this woman's life. As an aside, had this patient been hospitalized and delivered successfully she might have been a candidate for mitral valvulotomy if she had pure mitral stenosis. Again I would agree that this is a preventable death, and for the third time would emphasize the failure of careful supervision by a physician experienced in handling cardiac problems.

A Clinicopathological Conference

Edited Under the Auspices of the Ohio Society of Pathologists

CHARLES BLUMSTEIN, M.D., *President*

Presentation of Case

THIS 47 year old white woman had had tachycardia for the last 20 years and had been taking digitalis for the last 10 years and quinidine at intervals for the last three years. She was admitted to the University Hospital, Columbus, Ohio, with complaints of tachycardia, dull substernal pain, shortness of breath and weakness of 48 hours' duration. She had a history of gall-bladder disease two years prior to admission. Her family and social history were noncontributory.

The patient was asthenic, anxious and in distress. Her neck veins were distended. The pulse rate was 136 per minute, the blood pressure 100/70. There was a coarse thrill over the left precordium and a to-and-fro blaring systolic murmur present at the apex. A systolic grade 3 murmur could be heard at the third interspace to the left of the sternum. The liver was enlarged and pulsating. All her laboratory data were within normal limits. The electrocardiogram showed a complete right bundle branch block and right ventricular enlargement. Her x-ray examination showed hilar pulmonary vascular congestion and cardiomegaly with a prominent pulmonary artery segment and a small aortic knob.

The patient was treated with quinidine, sedation, and diuretics and her heart beat reverted to regular sinus rhythm. She remained afebrile and was discharged after 18 days' hospitalization.

Four months later she was again admitted with the chief complaint of tachycardia. In the hospital her pulse rate was 88/min. and regular, her blood pressure 88/60. The neck veins were slightly distended. The lungs were clear except for a few basal rales. Examination of the heart disclosed a regular rhythm, a left parasternal systolic murmur, and cardiomegaly. The liver again was large, tender and pulsating. All her laboratory tests were normal. Her electrocardiogram showed right ventricular preponderance and a right bundle branch block. Fluoroscopic examination revealed a prominent pulmonary artery segment. Cardiac catheterization showed an elevated blood pressure in the right ventricle, right auricle and pulmonary artery. Oxygen saturation studies showed: right ventricle 87.6 per cent; right atrium 89.2 per cent; high right atrium 55.3 per cent; pulmonary artery 86.7 per cent. The patient tolerated the

Presented by

- Neil Andrews, M.D., Columbus, and
 - Emmerich von Haam, M.D., Columbus.
- Edited by Dr. von Haam.

diagnostic procedures well and after 11 hospital days was discharged on digitalis and quinidine.

One year after her first admission the patient was admitted for evaluation for cardiac surgery. Because of increasing respiratory difficulty, recurrent edema, hepatomegaly, and attacks of tachycardia in early mornings and evenings, it was felt that the patient was a candidate for cardiac surgery. Her blood pressure was 118/68, her respirations 20/min. and her pulse rate 84/min and regular. There was a harsh murmur over the entire precordium, best heard at the left third intercostal space; there were no diastolic murmurs. The liver was tender and enlarged. Cardiac surgery was performed on the ninth hospital day.

On the sixth postoperative day she experienced respiratory difficulties and complained of numbness around the mouth. Her blood urea nitrogen was 65 mg./100 ml., her sodium 130 mEq./L and the chlorides 80 mEq./L. She received 100 cc. of hypertonic saline in 12 hours and within the next 24 hours she developed ascites and edema of the lower extremities. Two thousand cubic centimeters of fluid were removed by paracentesis, and twice thoracentesis was performed to relieve her pleural effusion.

Two and a half years after her third admission she was readmitted for the last time. Since the last admission she had had two episodes of pneumonia. Her chief complaint now was severe shortness of breath and sudden pain in the left side of her chest radiating to her back. On her way to the hospital she coughed up a small amount of "brown" fluid.

Physical Examination: The patient was acutely ill, pale, emaciated, and dyspneic with severe diaphoresis and fatigue. Her blood pressure was 80/60, her pulse rate 110/min., her temperature 96°F. Examination of the heart revealed cardiomegaly with systolic and diastolic thrills at the apex; the heart sounds were loud with occasional premature ventricular contractions; no murmurs

could be heard. There was a pleuro-pericardial friction rub over the left chest posteriorly; her breath sounds were decreased in the right base. The liver was 8 cm. below the costal margin. There was no peripheral edema.

Laboratory Data: Her total white blood cell count was 15,250/cu. mm. with 93 per cent polymorphonuclear leukocytes; her hemoglobin, 14 grams; hematocrit was 47 per cent. X-ray examination revealed a large heart with a markedly dilated pulmonary artery and small aorta.

Hospital Course: The patient's temperature rose to 102°F. She was treated with penicillin, streptomycin and sedation. Twelve hours after admission her condition appeared critical and shortly thereafter she became unresponsive, cyanotic and died.

Clinical Discussion

DR. ANDREWS: Our patient was a 47 year old woman who had evidence of myocardial failure at the time she was admitted to the hospital for the first time. She had an enlarged heart, a systolic murmur at the apex, and a grade 3 systolic murmur at the third intercostal space on the left. In view of her heart failure, the systolic murmur at the apex does not particularly interest us at this moment, but we are concerned about the systolic murmur at the third intercostal space. We have to think of reasons to explain her tachycardia—of hyperthyroid disease, paroxysmal tachycardia, atrial fibrillation or atrial flutter.

In view of her normal cholesterol we can assume that she did not have thyroid disease. If we want to explain the enlarged pulmonary artery demonstrated by x-ray, we think of the possibility of pulmonary stenosis, which could account for her systolic murmur. We really can't go much further than that except to say that we might suspect an interatrial, or possibly an interven-tricular, septal defect, but at the age of 47 these possibilities are a little remote until we have more information, which we did gain during her second hospital admission.

She was admitted again because of the complaint of tachycardia. At this time cardiac catheterization was done and showed evidence of increased pressure and increased oxygen saturation in the pulmonary artery, right ventricle and right atrium. Thus we can rule out pulmonary stenosis because the pressure in the pulmonary artery was increased and we have to consider the problem of a left to right atrial shunt. This can be caused by an interatrial septal defect, an anomalous pulmonary vein drainage, or a rupture of the sinus of Valsalva into the right atrium. If this were a rupture of the sinus of Valsalva into the

right atrium, it is very unlikely that we would have a history of 20 years. This condition leads to acute cardiac symptoms which result in rapid failure and therefore does not fit this case.

If there were an anomalous drainage of the pulmonary veins to the right atrium, the superior or inferior vena cava, then the oxygen should be elevated in those vessels as well as in the right atrium. It might have been demonstrated at cardiac catheterization by actual insertion of the cardiac catheter into the anomalous vein from the right atrium. In anomalous drainage of the pulmonary veins the patient should be cyanotic because of the necessity of having an interatrial septal defect in order to get blood from the right atrium to the left side of the heart.

Septal Defect

We are left then with the diagnosis of an interatrial septal defect becoming symptomatic relatively late in life (27 years of age), and all her findings—a systolic murmur, the right ventricular enlargement, the evidence of right bundle branch block—are compatible with an interatrial septal defect. There is one thing that bothers me though in this diagnosis: she never had cyanosis. If she had been in several episodes of congestive heart failure, particularly when her peripheral blood pressure was only 88/60, I should expect some history of cyanosis. But there is none in the protocol. Therefore I have to also assume the presence of a mitral stenosis, or a Lutembacher's syndrome, so that there was never an opportunity for the blood to pass from the right atrium to the left atrium.

The patient subsequently improved, went home, and eight months later was admitted for cardiac surgery. On this admission it was specifically stated that she had no cyanosis, that her lungs were clear, her heart enlarged, and that a harsh systolic murmur was heard best at the third intercostal space on the left. If she had an interven-tricular septal defect the murmur should be at the fourth intercostal space and we should not have found an elevated oxygen saturation of the blood from the right atrium. I think we can therefore eliminate this diagnosis.

To review the circulation of blood in interatrial septal defect: Blood returns from the periphery to the right atrium, passes to the right ventricle, into the lungs, and is brought back by the pulmonary veins to the left atrium as oxygenated blood and passes through the opening in the interatrial septum back to the right heart. So there is a continuous re-circulation of blood through the pulmonary vascular tree.

If the pressure in the right atrium increases

above the pressure in the left atrium, as would occur in congestive failure, then blood could pass from the right atrium to the left atrium, resulting in peripheral cyanosis. If, however, we have mitral stenosis present, then she would have a continuous flow of blood from the left atrium to the right because of obstruction of the blood flow to the left ventricle. This could explain the absence of cyanosis in this patient when she went into failure. A patent foramen ovale defect would only allow blood to go from right atrium to left, and we can rule this out. A patient with a septum primum defect usually gets into trouble earlier in life than a patient with septum secundum defect, and they rarely have right bundle branch block. So I suggest that this patient probably had a septum secundum defect.

The patient had surgery probably consisting of closure of her interatrial septal defect and commissurotomy. She got along well for the first five days. We then have a series of blood studies which showed an elevated blood urea nitrogen and a lowering of the chlorides. I would surmise that this patient was given fluids during this post-operative period with minimal sodium in the fluid or in her diet, so that she actually developed water intoxication with dilution of her blood electrolytes and some increase in her intracellular fluid. She was then given 100 cc. of hypertonic saline and shortly developed signs of ascites and edema of the lower extremities. Here I believe we have evidence of this intracellular fluid becoming extracellular and being manifested in these two ways. She was then treated with diuretics, had a paracentesis with removal of 2000 cc. of fluid and lost essentially 1 pound a day for a period of 10 days.

Pulmonary Emboli

Her cardiac surgery was successful and she got along well for two and a half years except for a couple episodes of pneumonia. Then she had the onset of shortness of breath, sudden pain in the chest and coughing up of some brownish fluid. I think we have to explain this on the basis of pulmonary embolus with infarction, although we might consider the possibility of pneumonia, but I think infarction fits much better, with probably some secondary pneumonitis following infarction. The x-ray picture is compatible with an early pulmonary embolus since we might not see evidence of infiltration in the lung for some time after an actual embolus had occurred.

Why did she die? I think the immediate cause was the pulmonary embolus. But she had had some respiratory difficulty, perhaps unrelated to this. It is also not uncommon in patients with atrial septal defect to develop pulmonary hyper-

tension with sclerosis of the pulmonary arteries. This in turn will eventually lead to cor pulmonale and right heart failure.

General Clinical Discussion

QUESTION: Will you discuss very briefly the pulsating liver?

DR. ANDREWS: I think this was during her periods of cardiac failure and represented blood being pulsated back through the veins to the liver. It is not uncommon to have a pulsating liver under those circumstances.

QUESTION: Would it be possible to account for this on the basis of an interventricular septal defect and tricuspid insufficiency?

DR. ANDREWS: It is a possibility. We would always have to consider an Ebstein's syndrome, but I think it is a little more logical to assume an interatrial septal defect than an interventricular septal defect.

DR. KLASSEN: The patient had Lutembacher's defect, or as we would call it, Abbott's defect, as she described it one year before he did. Surgically, how did we approach it in those days? In those days we thought that if we could do a commissurotomy by finger fracture technique, possibly using a knife, we could reduce the pressure gradient between the left atrium and the left ventricle, which would allow more blood to flow into the left ventricle. With reduction in the intra-atrial pressure on the left, there would be less blood going to the right side of the heart and she would have less pulmonary hypertension.

The trouble is that when you treat mitral stenosis blindly, you sometimes produce insufficiency, which is very poorly tolerated, particularly in the presence of an interatrial septal defect. I doubt that her septum was closed. Three years ago we attempted to close some of them under hypothermia and we also did it by the blind technique from the outside. But those were usually unsuccessful because we usually would leave a small hole, sometimes a fairly large hole, and actually surgery by blind technique of closing an interatrial septal defect is not good. However, the patient apparently was improved, because she had been in trouble for 10 years and she went along for another 2½ years and apparently improved, and then finally died because she had a severely damaged myocardium.

At the present time this problem would have been solved in a different way, using the techniques of open heart surgery. We would open the right atrium, expose the septal defect, look through it, see the mitral valve, take scissors and accurately, under direct vision, cut the commis-

tures to the proper dimensions. We would close the interatrial septal defect under direct vision, putting a patch on it if necessary, and close the atrium. Even today this patient would still run a risk of probably 35 to 50 per cent operative mortality, because she had a damaged myocardium and severely damaged pulmonary vessels. What is the lesson? We hope that in the future these patients will be operated upon when they are young rather than when they are 47 and do not have much myocardium to go on.

Clinical Diagnosis

1. Lutembacher's syndrome.
2. Pulmonary embolus.
3. Pulmonary hypertension with pulmonary artery arteriosclerosis.

Pathological Diagnosis

1. Lutembacher's syndrome.
2. Bilateral bronchopneumonia.
3. Bilateral old and recent pulmonary infarcts.
4. Pulmonary atherosclerosis and fibrosis.

Pathological Discussion

DR. VON HAAM: This case was chosen not in order to discuss the fatalities incident to cardiac surgery but to judge the beneficial effect cardiac surgery may have on an individual.

The body was that of a normally developed, frail white woman with an estimated weight of 80 pounds. The right pleural sac contained about 1000 cc. of serosanguineous fluid, the left pleural sac 800 cc. of similar fluid. The right lung was adherent to the chest wall by old adhesions. The pericardial sac was completely obliterated by adhesions. The heart was greatly enlarged and weighed 675 grams. A large interatrial septal defect was seen measuring 4 to 5 cm. in diameter. It showed smooth edges and no evidence of previous repair. No interventricular septal defect was present.

The mitral valve appeared widely patent and measured 100 mm. in circumference. The edges of the valve appeared thickened. The right ventricle measured 8 mm. in thickness, the left ventricle 10 to 12 mm. The myocardium appeared reddish brown and firm. The root of the aorta showed several atheromatous deposits. The coronary arteries appeared normal. Each lung weighed approximately 600 grams. The lungs showed deep brown discoloration and dependent atelectasis. The right upper lobe showed a recent infarct. The right and left lower lobes showed older infarcts. In both lungs nodular areas of infiltrates could be recognized. The pulmonary

arteries showed deposits of yellow substance. No massive emboli or thrombi could be identified.

Microscopic Examination

Microscopic examination of the heart showed myocardial hypertrophy with mild fibrosis. The hypertrophy was prominent in the right ventricle. Sections of the mitral valve showed evidence of healed rheumatic disease with marked endocardial thickening and some vascularization. Examination of the lung showed old and recent infarcts, bilateral confluent bronchopneumonia and marked arteriosclerosis of the small and larger branches of the pulmonary artery.

In summary, we may state that Dr. Andrews was very correct in his prediction. The patient did have an acquired mitral stenosis of rheumatic origin and a large interatrial septal defect which apparently the surgeon did not succeed in closing. It is stated in the literature that these septal defects may get larger as the individual grows older because of the pull the large vessels have on the structure of the atria.

The appearance of the lungs also followed Dr. Andrews' prediction. The massive infarcts in some areas had already changed into bronchopneumonia, and there was all evidence of severe pulmonary hypertension. The remarkable incidence of repeated bouts of pneumonia and other respiratory troubles in patients with Lutembacher's syndrome has been stressed repeatedly in the literature without satisfactory explanation unless we explain it on the basis of pulmonary hypertension with capillary stasis. The frequent combination of interatrial septal defect and mitral stenosis is similar to the well-known simultaneous occurrence of congenital and acquired heart disease and can be explained by the traumatization of valves due to the altered circulation of blood through the heart.

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Diabetes Insipidus Following Closed Intracranial Trauma

Diabetes insipidus may be caused by closed intracranial injury. The time of injury to the onset of symptoms varies from three or four days to a few weeks. The period of recovery may be only a few days or may extend over a period of a few years. Symptoms persist indefinitely in the occasional case. Symptomatic treatment with posterior pituitary extract is effective and simple.—*Journal Indiana M. A.*, 52:359, March, 1959.

Proceedings of The Council . . .

Post-Convention Meeting Held at Columbus Office on Sunday, May 17; A Number of Questions Assigned to Committees for Study and Action

A REGULAR meeting of The Council, Ohio State Medical Association, was held in the Columbus Office on Sunday, May 17, 1959. All Councilors, except Dr. Hamwi and Dr. Tschantz were in attendance. Others attending were Mr. Stichter and the following members of the Columbus office staff: Nelson, Saville, Page, Edgar and Moore.

Following the introduction of new Councilors, President Mayfield recommended to The Council he be given authority to assign questions as they arise to various committees for study and report to The Council. Dr. Mayfield pointed out that this would expedite the handling of business matters. By official action, The Council voted such authority. Dr. Mayfield also explained the manner in which grievances are handled and requested each Councilor to make a report to The Council after the matter has been finally adjudicated by the local medical society.

On motion duly made, seconded and carried, the minutes of the meetings of The Council held on April 21st and April 23rd were approved.

The Executive Secretary presented a membership report showing the total membership of the OSMA as of May 15, 1959, 8,892 of which 7,935 are affiliated with the American Medical Association; compared to the following figures as of December 31, 1958—OSMA membership, 9,234; AMA affiliates 8,167.

Amendments Approved

Amendment adopted by the Lake County Medical Society to its Constitution and Bylaws on March 11, changing the date for regular meetings of the society, was approved by The Council, by official action.

A revised Constitution and Bylaws adopted by the Licking County Medical Society on March 31, 1959, was approved by official action.

Amendments adopted by the Summit County Medical Society to its Constitution and Bylaws on April 7, 1959, adding a new classification of members known as "employee members," were officially approved.

A revised Constitution and Bylaws adopted by the Guernsey County Medical Society on September 4, 1958, with amendments adopted by the society on January 8, 1959, was approved by official action, with the understanding that the sec-

ond paragraph of Article III relating to membership eligibility would be written in conformity with the Constitution and Bylaws of the Ohio State Medical Association. The Executive Secretary was instructed to send to the officers of that society a re-worded paragraph.

Dr. Mayfield asked the Councilors to make a special effort to have all of the county medical societies adopt the "model" Constitution and Bylaws or to adopt certain amendments to existing documents to bring them into conformity with the revisions which have been made during the past several years in the Constitution and Bylaws of the Ohio State Medical Association.

Vote for Fall Conferences

Dr. Mayfield discussed a recommendation which he had made in his inaugural address, namely, that a conference be held in each Councilor District this coming Fall. Each conference would be attended by officials of the Ohio State Medical Association and officials of each county medical society, as well as the public relations chairman of each county medical society. During the discussion it was agreed that there should be an afternoon session of one and a half or two hours, preceding dinner, at which general organization questions and problems would be discussed and that following the dinner there should be a session devoted to relationship between county medical societies and the various media of communication. Representatives of the press, radio and television of the area would be invited guests of the Association for the evening session.

By official action, The Council approved this plan and authorized Drs. Mayfield, Artman and Woodhouse, and Mr. Nelson and Mr. Saville to work out all details.

Resolutions Referred

The Council then authorized referral of certain resolutions adopted at the 1959 Annual Meeting to the following committees for consideration and report back to The Council:

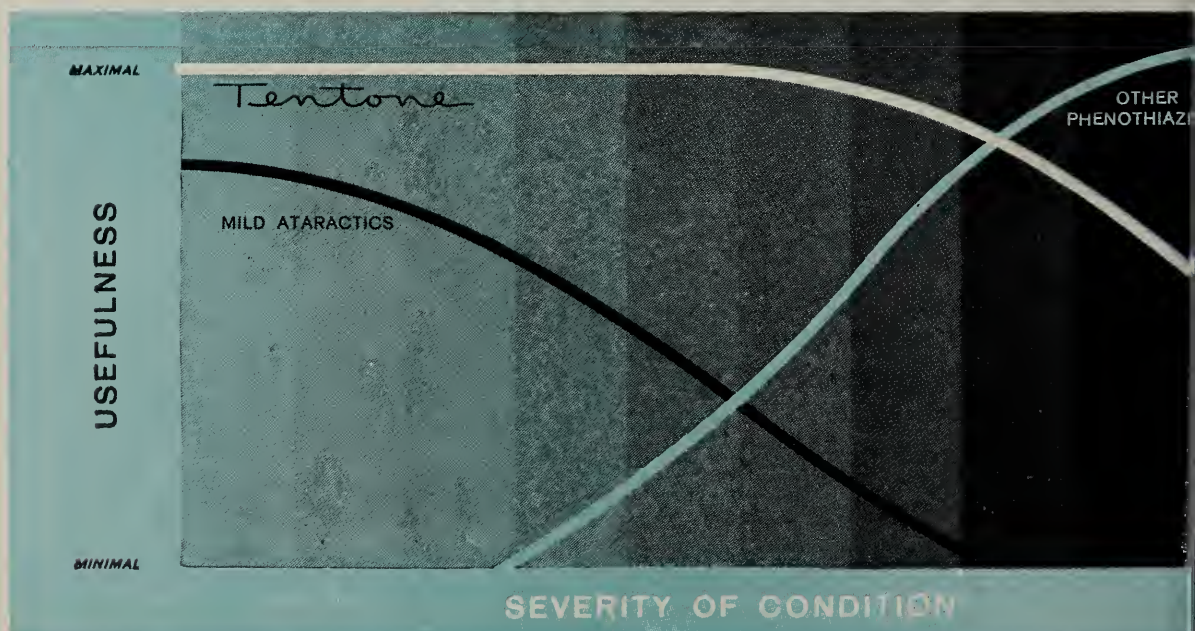
Resolution relating to revisions of Ohio Medical Practice Act—Judicial and Professional Relations Committee.

Resolution proposing modernization of the public health laws and rules and regulations of Ohio pertaining to contagious diseases—To Presi-

(Continued on Page 982)

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dent Mayfield for assignment to committee at later date.

Resolution on medical insurance for aged—To Committee on Care of the Aged.

Resolution relating to change in Chapter 4, Section 8, of the Bylaws of the OSMA—To Mr. Stichter and Executive Secretary Nelson.

Resolution regarding speed and noise of emergency vehicles—To Committee on Traffic Safety.

A communication from a member asking for a study of possible changes in the regulations relating to maternity hospitals so as to make available certain beds in maternity sections for so-called "clean gynecological cases" was referred to the Committee on Maternal Health.

Industrial Health

A report of the Committee on Industrial Health on a meeting held February 25, 1959, in the Columbus Office, was received and **officially approved.**

A recommendation of that committee that there be a study made of the question of impartial medical testimony and possible follow-up action, was **referred by official action,** to the Judicial and Professional Relations Committee.

Maternal Health Committee

A report from the Committee on Maternal Health was received by The Council. **By official action,** the committee was instructed to cooperate with the officials of District V, American College of Obstetricians and Gynecologists, on a proposed obstetrical-anesthesia survey, providing the committee wishes to participate and providing that the sponsors of the project will consent to elimination of a section in the proposed survey blank asking various questions regarding charges, billings, and other financial data.

Belmont County Question

A communication from Dr. Murray B. Hunter, Chairman of the Professional Relations Committee at the Bellaire Clinic, Bellaire, Ohio, was considered. The communication read as follows:

"You are probably well aware of the problems caused by the persistent refusal of the Belmont County Medical Society to consider applications from physicians who practice with the Bellaire Clinic. A possible solution, other than legal anti-trust action, seems to lie in the formation of an additional society, of a county society nature, which could then affiliate with the Ohio State Medical Association. Would you please forward the appropriate information from the State Constitution and By-Laws as well as your advice on the standard procedure to be followed in the formation of a society. We find it progressively

more difficult to restrain some of our members from taking legal action. The longer this status of non-membership in the American Medical Association exists the more serious becomes the damages against the excluded physicians. Thank you for your prompt attention to this matter."

By official action, The Council authorized the Executive Secretary to send to Dr. Hunter a copy of the current Constitution and Bylaws of the Ohio State Medical Association and to call his attention specifically to Chapter 10, Section 2, of the Bylaws relating to procedures for the chartering of county medical societies.

Polio Program

A communication from Dr. Thomas M. Rivers, Vice-President, Medical Affairs, The National Foundation, was then discussed. The communication pointed out that The National Foundation, through its chapters, is making available a Revolving Fund of \$500,000 to expedite the establishment of low-cost polio immunization clinics in sections of certain communities which show an extremely low polio vaccination rate. The letter pointed out that financial assistance is being offered to three Ohio cities, Cleveland, Cincinnati and Columbus for a demonstration vaccination program. The letter pointed out that the primary responsibility would rest in the hands of the local health authorities and that the cooperation of physicians in the community is to be solicited. Dr. Rivers asked for comments on the part of the Ohio State Medical Association.

After a discussion the Executive Secretary was **instructed to write to Dr. Rivers as follows:**

It is the opinion of The Council that, under the existing policy of the Association on immunization procedures, it would be the responsibility of each county medical society to decide whether or not the demonstration program should be inaugurated in its area of jurisdiction. Moreover, he was instructed to advise Dr. Rivers that this principle is set forth in the policy of the Association adopted by the House of Delegates at the 1957 Annual Meeting of the Association, May 13-16, and reading as follows:

"WHEREAS, The Ohio State Medical Association is of the opinion that each county society should carry out immunization procedures that seem more effective for the area concerned, in the best interests of the community, and

"WHEREAS, Personal health is the responsibility of each individual, and

"WHEREAS, The state of emergency has ceased to exist, and

"WHEREAS, Certain national organizations are entering more and more into the field of

medicine and offering free medicines, vaccines, and attempting to set up nationally, immunization programs other than suitable for local community conditions,

"THEREFORE BE IT RESOLVED, That the Ohio State Medical Association oppose mass inoculation procedures, except in epidemics or emergencies or for indigent programs, and approve of these procedures in the private doctor's office or facilities directly under his control, and

"BE IT FURTHER RESOLVED, That each county medical society re-affirm its continuing program of public education as to the value of immunization procedures relating to all diseases."

Legal-Ethical Question

A letter from a member asking for advice on legal and ethical matters with respect to a re-organization of the group practice in which he participates, was discussed. The Executive Secretary was instructed to advise the member as follows:

"Since the Ohio State Medical Association is not permitted under the law to furnish legal advice to individual members on their individual professional matters, no advice can be given to you regarding the legality of your proposed re-organization plan. Legal advice should be secured by you from your own attorney.

"Enclosed are certain documents and pronouncements of the American Medical Association and the Ohio State Medical Association which may be helpful to you in evaluating whether or not your proposed plan complies with the Principles of Medical Ethics.

"It is recommended that you confer with the proper officials of your county medical society on the ethical aspects of this question inasmuch as a county medical society is the court of first resort on all matters of ethics involving its members."

Legislative Report

Mr. Saville gave a detailed report on pending State legislation.

Membership Matters

A communication from the American Medical Association asking that the Association consider the possibility of revising its membership provisions so that membership would be extended to physicians in the armed forces, Public Health Service, and Veterans Administration services, not now eligible for State membership, was discussed. It was the opinion of The Council that no change should be made at the present time in the Bylaws of the Association which provide that a physician, to be eligible for membership in the Ohio State Medical Association, must be licensed

to practice medicine in Ohio unless he is serving a hospital internship or residency and is licensed to practice in some other State but is not a member of a medical society of any other State. It was pointed out that physicians in the armed forces, Public Health Service and Veterans Administration services can obtain membership direct in the AMA and that in most areas in Ohio such physicians are extended courtesy privileges by the local medical society.

Wants Stand-Off in Dues

A letter from the Secretary of the Massachusetts Medical Society was reviewed. The letter suggested that the Massachusetts Society and the OSMA waive annual dues for any member of either Association who might move to the other State and affiliate with the society of that State. By official action, The Council decided that the existing procedure should be followed in Ohio, namely, that physicians affiliating with the Ohio State Medical Association would be expected to pay the current annual dues of the OSMA even though they might have been members of the medical society of the State from which they have moved.

Reimbursement Rejected

Consideration was given to a letter from a member who was a speaker on the recent annual meeting program, requesting reimbursement for expenses incurred in attending the meeting. After due consideration, The Council voted that the existing policy of the Association should be continued, namely, that members participating in the annual meeting program should not be reimbursed for expenses incurred in attending the annual meeting. Members of The Council pointed out that it believed it is an obligation on the part of members to attend the annual meeting; that participation in the program is considered by many physicians as an honor and a privilege; that any member who feels that he cannot attend the annual meeting without a financial sacrifice has the right to reject the invitation to be a program participant.

Report by Dr. Hudson

The Council received a report from Dr. Charles L. Hudson, regarding a conference held in Pittsburgh on February 28-March 1, 1959, under the sponsorship of the American Medical Association to discuss two matters, namely, relationship with third-party medical care plans and activities with respect to medical care programs for aged citizens. In receiving this report, The Council expressed its appreciation to Dr. Hudson for a very enlightening report. Also, it thanked him as well as Drs.

Woodhouse, Dooley and Yantes for having attended the conference as official representatives of the Ohio State Medical Association.

Butler County Resolution

A copy of a letter from the Butler County Medical Society to Ohio Medical Indemnity, Inc. recommending certain changes in the schedule of benefits and the contract of OMI was read and discussed. The Executive Secretary advised The Council that the communication had been considered by the Board of Directors of OMI at the April meeting of the Board of Directors and was referred to the Executive Committee for study and any follow-up action which might be deemed advisable and practical.

Report on Insurance Program

A report from Turner and Shepard, Inc. on the OSMA Group Life Insurance Plan was received and discussed. The report pointed out that as of March 18, 1959 1,839 members and 625 employees of members were covered by the program. The Executive Secretary advised The Council that a re-enrollment program will be started very soon in the Fifth Councilor District and that re-enrollment will be started soon in other districts.

Children-Youth Conferences

The Executive Secretary requested Councilors to urge their county societies to participate in the local meetings which will be held during the next several months preliminary to a State conference at which reports and recommendations will be considered for the White House Conference on Children and Youth to be held in 1960 in Washington D. C. Reference was made to the recent Secretary's Bulletin distributed from the Columbus Office to all county medical societies on this matter.

The Executive Secretary reported also that arrangements have been made for the Fall meeting of The Council at the Granville Inn, Granville, Ohio, on Friday evening, September 18, and Saturday and Sunday, September 19 and 20.

There being no further business, The Council adjourned to meet at the call of the President.

Attest: CHARLES S. NELSON,
Executive Secretary.

A pilot study on breath control as practiced by professional singers is now underway at the VA hospital in East Orange, N. J., to find out the beneficial results of breath control in the treatment of emphysema.

Do You Know?...

The Ohio State University Development Fund has received a gift of \$100 from the Clinton County Memorial Hospital Staff, Wilmington, in memory of the late Joseph Harlan Frame, M. D. The gift was earmarked for medical education.

* * *

E. J. Faulkner, President, Woodmen Accident and Life Company, Lincoln, Nebraska, has been elected Chairman of the Health Insurance Council, succeeding Morton D. Miller, Vice-President, The Equitable Life Assurance Society of the United States.

* * *

OSMA Administrative Assistant Charles W. Edgar was elected chairman of the Health Education Section, Ohio Public Health Association, May 19, during the OPHA annual meeting in Columbus.

* * *

Dr. Edwin H. Artman was honored by the local Ross County Academy of Medicine upon his return home after being named President-Elect of the Association. A reception in his honor was given on Sunday, April 24, at the home of Dr. and Mrs. Robert Quinn. Dr. Quinn is president of the local Academy.

* * *

Dr. Thomas H. Sutherland, Marion, retired as secretary-treasurer of the Aero Medical Association, after holding that post for 12 years. The group at the annual meeting in Los Angeles voted to change its name to the Aero-Space Medical Association.

* * *

At the recent national assembly of the American Academy of General Practice held in San Francisco Dr. Herbert W. Salter, of Cleveland, was elected to a three year term on the Board of Directors.

* * *

Dr. James Z. Appel, Lancaster, Pa., physician and member of the Board of Trustees of the AMA, has been appointed as the AMA's representative on the Physician Advisory Committee of the American Association of Medical Assistants.

* * *

The Second George M. Curtis Lecture was given at the Ohio State University Health Center on May 25. Dr. Richard H. Meade, of Grand Rapids, Michigan, spoke on "The Evolution of Pulmonary Resection." The George M. Curtis Lectureship was established in 1956 in honor of Dr. Curtis, Professor Emeritus of Surgery at the Ohio State University Medical School.

AMA Atlantic City Session . . .

Policy Statement on Third-Party Plans and Free Choice Is Adopted by House of Delegates; Summary of Business Session at the 1959 Meeting

REPORT of the A. M. A. Commission on Medical Care Plans, relations between medicine and osteopathy, the report of the Committee on Preparation for General Practice and the issue of compulsory Social Security coverage for self-employed physicians were among the major subjects which brought important policy actions by the House of Delegates at the American Medical Association's 108th Annual meeting held June 8-12 in Atlantic City.

Another highlight of the meeting was the appearance of President Dwight D. Eisenhower, who addressed an over-flow audience of more than 5,000 at the Tuesday night inauguration of Dr. Louis M. Orr of Orlando Florida, as the 113th president of the A. M. A. It marked the first time that a President of the United States has addressed an A. M. A. annual or clinical meeting.

Askey New President-Elect

Dr. E. Vincent Askey of Los Angeles, speaker of the House of Delegates since 1955, was named president-elect for the coming year. Dr. Askey will succeed Dr. Orr as president at the association's annual meeting in June, 1960, in Miami Beach.

The 1959 Distinguished Service Award of the American Medical Association was voted to Dr. Michael E. De Bakey of Houston, Texas, chairman of the department of surgery at Baylor University College of Medicine, for his outstanding contributions in the field of cardiovascular surgery. Dr. De Bakey received the award at the Tuesday night inaugural ceremony.

Ohio's Delegates

Ohio was represented in the House of Delegates by the following: Dr. George A. Woodhouse, Pleasant Hill; Dr. C. C. Sherburne, Columbus; Dr. Herbert B. Wright, Cleveland; Dr. L. Howard Schriver, Cincinnati; Dr. Carll S. Mundy, Toledo; Dr. Carl A. Lincke, Carrollton; Dr. Paul A. Davis, Akron; Dr. Charles L. Hudson, Cleveland; and Dr. Richard L. Meiling, Columbus. In addition, Dr. Charles L. Leedham, Cleveland, represented the Section on Military Medicine, and Dr. Walter J. Zeiter, Cleveland, served as delegate from the Section on Physical Medicine.

The following Ohioans served on reference committees: Dr. Sherburne, committee on execu-

tive session; Dr. Davis, committee on legislation and public relations; Dr. Wright, committee on sections and section work; Dr. Hudson, special committee to consider report of the Commission on Medical Care Plans. Dr. Woodhouse, as a member of the AMA Judicial Council, helped prepare the Council's report on osteopathy which was acted upon by the House of Delegates.

Eisenhower Address

President Eisenhower, speaking at the inaugural ceremony in the ballroom of Convention Hall, warned that inflation posed the greatest danger to the traditional, free enterprise practice of medicine. The cost of inflation, he said, "is not paid in dollars alone but in increasingly stagnated progress, lost opportunities, and eventually, if unchecked, in lost freedoms for the doctor and the patient." Mr. Eisenhower also expressed gratification at learning of A. M. A. leadership in the program to meet the health care needs of the aged.

Commission on Medical Care Plans

The House of Delegates received Part I of the report of the Commission on Medical Care Plans as information only and then acted upon the Commission recommendations item by item. The House adopted 36 of the recommendations without change, but rewrote three which relate to miscellaneous and unclassified plans. The changed recommendations now read as follows:

B-4. "In an effort to decrease, or at least to prevent an increase, in the over-all cost of health care, study should be given to the removal of the requirement of hospital admission as the only condition under which payment of certain benefits will be made."

B-6. "Medical care plans should be encouraged to increase their efforts to provide health education and information concerning the coverage of their subscribers."

Free Choice Policy

B-16. "The American Medical Association believes that free choice of physician is the right of every individual and one which he should be free to exercise as he chooses. Each individual should be accorded the privilege to select and change his physician at will or to

select his preferred system of medical care and the American Medical Association vigorously supports the right of the individual to choose between these alternatives."

In connection with free choice of physician, the House also requested the Board of Trustees to transmit to all constituent medical associations the "far-reaching significance" of Recommendation A-7, which says:

"'Free choice of physician' is an important factor in the provision of good medical care. In order that the principle of 'free choice of physician' be maintained and be fully implemented, the medical profession should discharge more vigorously its self-imposed responsibility for assuring the competency of physicians' services and their provision at a cost which people can afford."

Choice of Plans Advocated

The House also strongly endorsed Recommendation B-11, which declares that "Those who receive medical care benefits as a result of collective bargaining should have the widest possible choice from among medical care plans for the provision of such care."

Many of the Commission recommendations urged increased activity by state and county medical societies and the American Medical Association in such fields as continuing study and liaison, closer attention to legal and legislative factors, and the development of guides for the relationship between the medical profession and the various types of third parties. To carry out three of the recommendations involving A. M. A. activities, the House also approved a seven-point program which it requested the Board of Trustees to transmit to the Division of Socio-Economic Activities for immediate attention.

Medicine and Osteopathy

In considering a special report of the Judicial Council on the subject of osteopathy, the House adopted the following policy statement regarding interprofessional relations:

"(A) All voluntary professional associations between doctors of medicine and those who practice a system of healing not based on scientific principles are unethical.

"(B) Enactment of medical practice acts requiring all who practice as physicians and surgeons to meet the same qualifications, take the same examinations and graduate from schools approved by the same agency should be encouraged by the constituent associations.

"(C) It shall not be considered contrary to the Principles of Medical Ethics for doctors of medicine to teach students in an osteopathic college which is in the process of being converted

into an approved medical school under the supervision of the A. M. A. Council on Medical Education and Hospitals.

"(D) A liaison committee be appointed by the Board of Trustees of the American Medical Association to meet with representatives of the American Osteopathic Association, if mutually agreeable, to consider problems of common concern including inter-professional relationships on a national level."

In another action concerning osteopathy, the House recommended that the American Medical Association representatives on the Joint Commission Accreditation of Hospitals suggest to the Joint Commission that they inspect upon request and consider for accreditation without prejudice those hospitals required by law to admit osteopathic physicians to their staff.

Preparation for General Practice

The House approved and commended the final report of the Committee on Preparation for General Practice, which proposes a new two-year internship program for medical school graduates planning to become family physicians. To avoid unnecessary confusion, the House deleted only one sentence which read: "Indeed, the committee believes that the one year internship actually encourages inadequate preparation for general practice." The committee on Preparation for General Practice included representatives from the A.M.A. Council on Medical Education and Hospitals, the American Academy of General Practice and the Association of American Medical Colleges.

The suggested program would include a basic minimum of 18 months hospital training in the diagnostic, therapeutic, psychiatric, preventive and rehabilitative aspects of medicine and pediatrics in a very broad sense, including care of the newborn. A physician then could elect to spend the remaining six months for additional training in other segments of the program. The committee stated, however, that participants who plan to practice obstetrics would be expected to spend at least four months of the elective period in obstetrical training.

The report declared that "the graduate program of two years in preparation for family practice should be planned and implemented as a unified whole" with a maximum continuity of assignment in specific services. The program also calls for adequate experience in outpatient care and emergency room service.

Social Security

In considering five resolutions on the subject of compulsory Social security coverage for self-employed physicians, the House disapproved of

four and adopted one reaffirming its opposition to the compulsory inclusion of physicians. In so doing, the delegates expressed concern over the possible effects that a change of policy might have on the Association's entire legislative program, particularly with respect to the Forand Bill.

The House also recognized "the apparent growing demand by physicians for economic security" and requested the Board of Trustees to investigate the possibilities of developing group insurance and retirement plans which could be made available to Association members. It accepted a reference committee suggestion "that the American Medical Association continue and expand its educational program to inform its members of the economic, social and moral advantages of economic security obtained within the framework of our free enterprise system rather than through the mechanisms of governmental Social Security."

Ohio's Resolution

One resolution was presented by Dr. Woodhouse on behalf of the Ohio State Medical Association, as authorized by the OSMA House of Delegates. It read as follows:

"WHEREAS, There is widespread misunderstanding of the policy of the American Medical Association regarding the acceptance of funds for the American Medical Research Foundation, and

"WHEREAS, There are groups and agencies ready and willing to give funds for health research to the American Medical Research Foundation, and

"WHEREAS, The House of Delegates of the Ohio State Medical Association on April 23, 1959, expressed the belief that the American Medical Research Foundation should accept funds offered by any legitimate source,

"THEREFORE BE IT RESOLVED, That the House of Delegates of the American Medical Association instruct the American Medical Research Foundation to accept funds offered by any legitimate source."

Resolution Not Approved

The Reference Committee on Miscellaneous Business, to which the resolution was referred, submitted the following report which was approved by the House of Delegates:

"This resolution, No. 5, relating to the American Medical Research Foundation, was discussed at length. In any consideration of this resolution three important facts must be considered.

"(1) The AMRF is an entirely independent organization incorporated in the state of Illinois and is not legally a part of the American Medical Association although created by it.

"(2) Neither the House of Delegates nor the Board of Trustees of the AMA can direct or order the AMRF to take the action suggested by this resolution.

"(3) The AMRF may at present under its Constitution and Bylaws accept funds from any legitimate source.

"It is the recommendation of your committee that resolution No. 5 not be approved although we agree with its intent in urging the AMRF to increase its activities and to 'get off the ground,' so to speak. We would urge that the Foundation provide the House of Delegates with a progress report from time to time."

Miscellaneous Actions

In dealing with a wide variety of other subjects, the House also: Urged all physicians to participate more fully in community activities and socioeconomic matters in their own communities but agreed that no change should be made at this time in Article II of the Constitution, which states Association objectives;

Approved in principle the aims and objectives of the President's Council on Youth Fitness and the Citizens Advisory Committee on the Fitness of American Youth;

Accepted a Board of Trustees recommendation that the 1962 Annual Meeting be held in Chicago; the 1960 meeting will be in Miami Beach and the 1961 session in New York City;

Expressed heartfelt thanks to the Committee on Amphetamines and Athletes, which has completed its assignment;

Requested the Board of Trustees to study the problems and possibilities of establishing an A. M. A. - sponsored medical scholarship and/or loan program;

Approved the inclusion of *Today's Health* as a benefit of dues-paying membership and urged members to make it available to their patients;

Recommended that state medical societies, where advisable, initiate legislative efforts to eliminate cancer quackery;

Received a progress report indicating "phenomenal progress" in the field of health insurance coverage for the aged since the Minneapolis meeting last December;

Gave a rising vote of thanks to Dr. Joseph D. McCarthy, who finished his term as chairman of the Council on Medical Service;

Reaffirmed its full support of the Educational Council for Foreign Medical Graduates;

Endorsed the purposes outlined in the initial report of the Medical Disciplinary Committee;

Urged every A. M. A. member to give a sub-

stantial gift to the medical schools through the American Medical Education Foundation; and

Expressed appreciation for the outstanding disaster medicine program presented by the United States Army Medical Service on June 6, 1959, in Atlantic City.

Election of Officers

In addition to Dr. Askey, the new president-elect, the following officers were selected:

Vice-president, Dr. James Stanley Kenney of New York City; speaker of the House of Delegates, Dr. Norman A. Welch of Boston, and vice speaker, Dr. Milford O. Rouse of Dallas, Tex.

Dr. R. B. Robins of Camden, Ark., and Dr. Hugh H. Hussey, Jr., of Washington, D. C., were re-elected for five year terms on the Board of trustees. Also elected to the Board, for the first time, was Dr. Percy E. Hopkins of Chicago.

Dr. J. M. Hutcheson of Richmond, Va., was re-elected to the Judicial Council. Re-elected to the Council on Medical Education and Hospitals were Dr. Charles T. Stone, Sr., of Galveston, Tex., and Dr. W. Andrew Bunten of Cheyenne, Wyo.

Dr. Willard Wright of Williston, N. D., was elected, and Dr. J. Lafe Ludwig of Los Angeles was re-elected to the Council on Medical Service. Dr. William Hyland of Grand Rapids, Mich., was re-elected to the Council on Constitution and Bylaws.

Tax Decision on Pregnancy

Internal Revenue Service has defined what sickness is when it strikes a pregnant wage earner, such definition to determine whether sums received constitute sick pay and are thus excludable from income. Absence from work in time of pregnancy is *not* sickness per se, IRS reaffirms. For tax purposes, it was held that "sickness" begins with onset of labor and ends when the woman's physical incapacity as result of childbirth or miscarriage is terminated. Otherwise it is required that a physician certify that the pregnant woman's absence from work is precautionary against miscarriage, in order to gain exclusion of wages from gross income.

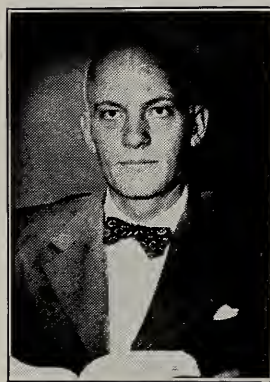
Dr. Robert Tschantz, Canton, new Councilor of the Sixth District, was recently named president of the Hospital Bureau of Canton.

At the recent meeting of the American Association of Pathologists and Bacteriologists, Dr. Robert P. Bolande, Western Reserve University, presented a paper entitled, "Inclusion-Bearing Cells in the Urine During Measles and Other Acute Viral Infections."

Dr. Douglas Bond Is Appointed Dean of Western Reserve Medical School

Dr. Douglas D. Bond was elected dean of the School of Medicine at a meeting of the Western Reserve University board of trustees on June 3, it was announced by WRU President John S. Millis. Dr. Bond will assume his new duties September 1.

In addition, Dr. Joseph T. Wearn, presently dean of the school, was appointed to the newly-created post of vice-president for medical affairs. In making the announcement, the president said: "This arrangement will make it possible for Dr. Wearn to devote his major efforts to obtaining support for the School of Medicine."



Douglas Bond, M. D.

Dr. Bond came to Reserve in 1945 as professor of psychiatry and director of the division in the University Hospitals from Army Air Force Headquarters in Washington, D. C., where he had been chief consultant and director of psychiatry.

A native of Waltham, Mass., Dr. Bond in 1934 won his bachelor of arts degree from Harvard College. His graduate work was done at the University of Pennsylvania Medical School where he received his M.D. degree in 1938. He was awarded an honorary doctor of science degree by Heidelberg College in 1953.

In addition to his duties at WRU, Dr. Bond has been expert consultant to the Secretary of War on personnel procurement, management and policy (1948-50); medical adviser to the American Red Cross (1950-51); and consultant on neuropsychiatry to the medical director of the Veterans Administration (1946-48).

Dr. Bond's memberships include: American Medical Association; American Psychiatric Association; Group for the Advancement of Psychiatry; Ohio State Medical Association; Cleveland Academy of Medicine; Cleveland Society of Neurology and Psychiatry; Peripatetic Club; dean's committee of Veterans Administration; diplomate in psychiatry, American Board of Neurology and Psychiatry; and American Psychoanalytic Association. He is a former member of the Committee on Medical Sciences, Research and Development Board.

He is the author of numerous books and articles.

Ohioans on AMA Program . . .

Many Physicians from This State Take Part in the Elaborate Program at Atlantic City or Participate in Various Phases of Scientific Exhibit

MANY Ohio physicians were among those who participated in the Scientific Program or presented exhibits at the 1959 Annual Session of the American Medical Association in Atlantic City, June 8-12.

Doan Is Speaker

Dr. Charles A. Doan, dean of the Ohio State University College of Medicine, Columbus, gave a general summary of a Symposium on "The Ramifications of Certain Diseases of the Blood," during a General Scientific Meeting.

Dr. Carl Erwin Wasmuth, Cleveland, discussed the subject, "Legal Liability of the Anesthesiologist and the Surgeon," before the Section on Anesthesiology.

Obstetrical Anesthesiology

Dr. William A. Cull, Cleveland, spoke on "Obstetrical Anesthesiology," as part of a "Symposium on Childbirth—Progress in Management," before a joint meeting of the Sections on Anesthesiology, Diseases of the Chest, General Practice, Nervous and Mental Diseases, Obstetrics and Gynecology, Pediatrics and Preventive Medicine.

Dr. Kenneth C. McCarthy, Toledo, was a member of the executive committee of the Section on Anesthesiology.

Drs. Kenneth H. Burdick and John R. Hase-rick, Cleveland, presented a paper entitled, "Herpes Simplex Following Decompression Operations for Trigeminal Neuralgia—Attempts to Modify by Local Use of Hydrocortisone Preparations," before the Section on Dermatology.

Drs. Lawrence C. Goldberg and Joel Barkoff, Cincinnati, presented a paper on "The Routine Treatment of Dermatoses with Intravenous Prednisolone Succinate," before the Section on Dermatology.

Post-Coronary Patient

Dr. Robert S. A. Green, Cincinnati, spoke on "Retraining of the Post-Coronary Patient," before a joint meeting of the Section on Diseases of the Chest with the Section on Preventive Medicine.

Dr. Robert M. Zollinger, Columbus, discussed the subject, "Surgical Management of Gastric Ulcer," as part of a Symposium on Gastric Ulcer before a joint session of the Sections on Gastroenterology and Proctology, Pathology and Physiology, and Radiology. Dr. Zollinger also parti-

cipated in one of the motion picture presentations as part of a Symposium on The Acute Abdomen.

Dr. Harold Ginsberg, Cleveland, spoke on the subject, "Adeno Viruses," as part of a Symposium on the Viruses before the Section on General Practice.

Dr. Bernard F. Brofman, Cleveland, presented a report before the Section on General Practice entitled, "Beck Operation for Coronary Heart Disease: Long Term Results (3-5 years) After Operation in a Series of 110 Consecutive Patients."

Angina Pectoris

Dr. Claude S. Beck, Cleveland, participated in a panel discussion on "The Management of Intractable Angina Pectoris," before the Section on Internal Medicine.

Dr. Walter H. Maloney, Cleveland, gave a report as representative to the Scientific Exhibit from the Section on Laryngology, Otology and Rhinology.

Dr. Edward W. Harris, Columbus, presented a talk on "Symptoms Referable to the Eustachian Tube," before the Section on Laryngology, Otology and Rhinology.

Dr. George E. Ruff, Wright-Patterson Air Force Base, Dayton, spoke on the subject, "Medical Criteria in Space Crew Selection" before the Section on Military Medicine.

Civil Defense

Dr. Richard L. Meiling, Columbus, participated in a Panel Discussion on "Strike," before the Section on Military Medicine, discussing the secondary phases of activity following a possible nuclear attack.

Three persons from Wright-Patterson AFB participated in a Panel Discussion on "Some Aspects of Air Force Biodynamics Research," before the Section on Military Medicine. Dr. John P. Stapp was moderator, and Dr. Edward L. Brown and Dr. Neville P. Clarke participated.

Dr. Raymond R. Suskind, Cincinnati, was secretary of the Section on Miscellaneous Topics.

Dr. Daniel J. Kindel, Cincinnati, spoke on the subject, "The Management of Angiomas," during the session on Cutaneous Facial Disfigurements before the Section on Miscellaneous Topics.

Dr. Henry D. Beale, Toledo, discussed "Allergic

Reactions to Newer Drugs," during the Session on Allergy before the Section on Miscellaneous Topics.

Dr. Roger E. Scott, Cleveland, participated in a Panel Discussion on Ovarian Tumors before a joint session of the Section on Obstetrics and Gynecology and the Section on Pathology and Physiology.

Drs. A. M. Potts, S. S. West and J. Shrearer, Cleveland, presented a paper entitled "The Application of the Television Ophthalmoscope to Some Problems of Clinical Ophthalmology," before the Section on Ophthalmology.

Glaucoma

Dr. Elmer J. Ballintine, Cleveland, was co-author of a report on the subject, "Effect of Levo-Rotary Adrenalin 2 Per Cent on the Glaucomatous Eye," presented before the Section on Ophthalmology.

Drs. James E. Bennett, James R. Armstrong, Raymond E. Jones and Fillmore Schiller, Cleveland, were co-authors of a report entitled, "Conjunctivo Antro Rhinostomy," presented before the Section on Ophthalmology.

Dr. Donald J. Lyle, Cincinnati, spoke on "Ophthalmological Involvement in the Primary Demyelinating Diseases," before the Section on Ophthalmology.

Dr. Lorand V. Johnson, Cleveland, was secretary of the Association for Research in Ophthalmology which sponsored a program.

Drs. A. M. Potts and B. C. Friedman, Cleveland, sponsored a report on "Additional Studies on Corneal Transparency," presented during the program of the Association for Research in Ophthalmology.

Eye Research

Drs. M. B. Waitzman, E. J. Ballintine and H. F. Binder, Cleveland, co-sponsored a study, "Effect of an Aldosterone Antagonist on Aqueous Tumor," a report of which was given before the Association for Research in Ophthalmology.

Drs. T. G. Parkas and S. J. Cooperstein, Cleveland, were co-sponsors of a study on "The Role of Insulin in Lens Metabolism," reported during the program of the Association for Research in Ophthalmology.

Dr. James I. Kendrick, Cleveland, spoke on the topic, "The Treatment of Calcaneonavicular Bar," before the Section on Orthopedic Surgery. He also was representative of the Section to the Scientific Exhibit.

Dr. J. Beach Hazard, Cleveland, opened discussion on a paper, entitled "Problems in the Pathological Diagnosis of Carcinoma of the Thyroid,"

before a session of the Section on Pathology and Physiology.

Dr. Charles C. Higgins, Cleveland, spoke on the subject, "Extrophy of the Bladder—Review of 152 Cases," before the Section on Pediatrics in joint session with the Section on Urology.

Drs. Richard C. Britton and Paul A. Nelson, Cleveland, were co-authors of a paper on "Management of Patients with Edema of the Extremities," presented before the Section on Physical Medicine.

Drs. Mieczyslaw Peszczyński and Jan H. Bruell, Cleveland, co-sponsored a paper entitled "Evaluation of the Functioning of the Hemiplegic Patient," presented before the Section on Physical Medicine.

Dr. Keith C. Keeler, Akron, spoke before the Section on Physical Medicine on the subject, "The Knee—a Problem in Physics."

Drs. Ernest W. Johnson and Karl J. Olsen, Columbus, were authors of a study report entitled "Clinical Value of Motor Nerve Conduction Velocity Determination," presented before the Section on Physical Medicine.

Section Officers

The following Ohio physicians served as officers of the Section on Preventive Medicine: Dr. Robert A. Kehoe, Cincinnati, chairman; Dr. Wilford F. Hall, Dayton, vice-chairman; Dr. Frank Princi, Cincinnati, secretary; Dr. Paul A. Davis, Akron, representative to the Scientific Exhibit. Dr. Kehoe gave the Chairman's Address, and Dr. Hall spoke on the subject, "Aviation Medicine in the United States."

Dr. William A. Altemeier, Cincinnati, opened discussion on a paper entitled, "A Surgical Outbreak of Staphylococcal Infections Traced to an Individual Carrying Phage Strains 80-81 and 80-81-52-52A," presented before the Section on Surgery, General and Abdominal. He also was moderator of a color television showing entitled, "The Staphylococcal Problem."

Dr. Willem J. Kolff, Cleveland, participated in one of the motion picture program presentations entitled, "Machine Mimics Man (Artificial Kidney)."

Scientific Exhibit

Seven Ohio physicians participated in the Special Exhibit on Fractures. Dr. Ralph G. Carothers, Cincinnati, was chairman of the exhibit committee. The following Ohioans were demonstrators: Drs. I. J. Cordrey, Cleveland; Nicholas J. Giannestras, Cincinnati; Robert S. Heidt, Cincinnati; Charles U. Hauser, Hamilton; Paul R. Miller, Columbus; and John C. Schmerge, Cincinnati.

Dr. Charles L. Blumstein, Lima, was one of the

demonstrators for the Special Exhibit on Fresh Tissue Pathology.

Four Ohioans participated as demonstrators for the Special Exhibit on Pulmonary Function. They were Drs. Frank Princi, Cincinnati; J. F. Tomashefski, Columbus; H. S. Van Ordstrand and George Wright, Cleveland. Dr. Tomashefski also was one of the demonstrators in the "lung station" as part of exhibit sponsored as Representatives of Government Services.

Diabetes

In the Exhibit Symposium on Diabetes, a team from Ohio State University College of Medicine presented an exhibit entitled "Comparison of Oral Agents in the Treatment of Diabetes Mellitus." The team included Drs. Geo. J. Hamwi, Thomas G. Skillman, Lucy R. Freedy and William R. Roush.

Three Ohioans participated in daily diabetes conferences held in connection with the Diabetes Exhibit and directed by members of the American Diabetes Association. They were Dr. Geo. J. Hamwi, Columbus; Dr. T. P. Sharkey, Dayton, and Dr. Thomas Skillman, Columbus.

Drs. Norman O. Rothermich and Vol K. Phillips, Ohio State University College of Medicine, Columbus, presented the exhibit "The Drop-Latex Fixation Test for Rheumatoid Arthritis."

Drs. H. S. Van Ordstrand, W. R. Biddlestone, and L. J. McCormack, Cleveland Clinic, Cleveland, presented the exhibit, "Chronic Fibrosing Interstitial Pneumonitis — The Hamman - Rich Syndrome," in the Section on Diseases of the Chest.

Heart Surgery

Drs. Earle B. Kay, David Mendelsohn and H. A. Zimmerman, St. Vincent Charity Hospital, Cleveland, presented the exhibit, "Surgery of Acquired and Congenital Heart Disease," in the Section on Diseases of the Chest.

Dr. S. William Simon, Veterans Administration Center, Dayton, presented the exhibit, "Tests for Oral Drug Utilization," in the Section on Experimental Medicine and Therapeutics.

Drs. Arthur L. Scherbel and John W. Harrison, Cleveland Clinic Foundation, Cleveland, presented the exhibit, "Serotonin Sensitivity in Rheumatoid Arthritis and Related Diseases," in the Section on Experimental Medicine and Therapeutics.

A team from Western Reserve University School of Medicine, Cleveland, Drs. Harold B. Houser, Floyd W. Denny, Edward A. Mortimer, Jr., Charles H. Rammelkamp, Jr., and Ralph J. Wedgwood, presented the exhibit, "Streptococcal Infection and Rheumatic Fever—A Spectrum of Dis-

eases with a Specific Therapy," in the Section on General Practice.

Drs. Claude S. Beck, David S. Leighninger and Bernard L. Brofman, Cleveland, presented the exhibit, "Treatment of Anginal Pain and Protection Against Sudden Death," in the Section on General Practice.

Drs. James S. Hewlett, George C. Hoffman and John D. Battle, Jr., Cleveland Clinic, Cleveland, presented the exhibit, "Radioactive Isotopes in Hematology," in the Section on Internal Medicine.

Drs. Morris Plotnick and J. Campbell Howard, Cincinnati, presented the exhibit, "Some Guiding Principles in Geriatrics," in the Section on Internal Medicine.

Dr. C. G. Park, Aero Medical Laboratory, Wright-Patterson Air Force Base, presented the exhibit, "Some Aspects of Air Force Biodynamics Research," in the Section on Military Medicine.

Drs. William E. Hunt, J. N. Meagher, H. E. LeFever and William Molnar, Ohio State University Health Center, Columbus, presented the exhibit, "Angiographic Diagnosis of Brain Tumor Type," in the Section on Nervous and Mental Diseases.

OB Exhibits

Dr. Albert C. Lammert, Howard P. Taylor and Paul J. Sindelar, Cleveland Clinic, Cleveland, presented the exhibit, "Family - Centered Obstetrics," in the Section on Obstetrics and Gynecology.

Drs. Richard L. Meiling and Anthony Ruppersberg, Jr., Columbus, Columbus Obstetric and Gynecologic Society, presented the exhibit, "Maternal Mortality in Franklin County—A Decade of Maternal Death Studies," in the Section on Obstetrics and Gynecology.

Dr. Charles H. Hendricks, Cleveland, was one of the sponsors of an exhibit entitled "Induction of Labor with Synthetic Oxytocin," in the Section on Obstetrics and Gynecology.

Dr. Harry T. McFarland, Cincinnati, was one of the sponsors of an exhibit, "Treatment of Threatened Abortion," in the Section on Obstetrics and Gynecology.

Urinary Fistulas

Drs. James S. Krieger, Paul R. Zeit, Patricia A. Radcliffe and Roland W. Radcliffe, Cleveland Clinic, Cleveland, were sponsors of an exhibit, "Iatrogenic Urinary Fistulas," in the Section on Obstetrics and Gynecology.

Dr. Elmer J. Ballintine, Western Reserve University School of Medicine, Cleveland, was one of the sponsors of an exhibit entitled "Graphic Dem-

onstration of Medical Control of Open-Angle Glaucoma," in the Section on Ophthalmology.

Drs. J. I. Kendrick, George S. Phalen, L. J. McCormack, Cleveland Clinic, Cleveland, presented the exhibit, "Benign Soft Tissue Tumors of the Hand," in the Section on Orthopedic Surgery.

Drs. Joseph E. Brown, H. F. Inderlied and G. W. Wright, St. Luke's Hospital, Cleveland, presented the exhibit, "Cine-Arthrography in Prosthetic Hip Joint Reconstruction as Compared to Conventional Radiography," in the Section on Orthopedic Surgery.

Spinal Fusion

Drs. A. W. Humphries and William A. Hawk, Cleveland Clinic Foundation, Cleveland, presented the exhibit, "Anterior Spinal Fusion," in the Section on Orthopedic Surgery.

Drs. John W. King, Thomas F. O'Mara and Donald A. Senhauser, Cleveland Clinic, Cleveland, presented the exhibit, "Inheritance of Human Blood Groups," in the Section on Pathology and Physiology.

Drs. William H. R. Howard and Robert J. Izant, Jr., Ohio State University College of Medicine and Children's Hospital, Columbus, presented the exhibit, "Lower Intestinal Obstruction of Infancy and Childhood," in the Section on Pediatrics.

Drs. Atis K. Freimanis, William Molnar and T. R. Frye, Ohio State University Health Center, Columbus, presented the exhibit, "Chronic Bronchitis and Emphysema at Bronchography," in the Section on Radiology.

Duodenal Obstruction

Drs. William C. Strittmatter and Charles H. Brown, Cleveland Clinic, Cleveland, presented the exhibit, "Post-Bulbar Duodenal Obstruction," in the Section on Radiology.

Drs. Charles G. Lovingood, Frank L. Shively, Jr., and Albert M. Storrs, Dayton, presented the exhibit, "Polyvinyl Plastic as a Surgical Drape," in the Section on Surgery, General and Abdominal.

Dr. E. F. Poutasse, Cleveland, was representative from the Section on Urology to the Scientific Exhibit.

Drs. William E. Forsythe and Lester Persky, Cleveland, presented the exhibit, "Operative Ureteral Injury," in the Section on Urology.

Dr. Francis W. Logan, Delaware, University physician and director of the Health service at Ohio Wesleyan University, has been elected president of the Ohio College Health Association. Dr. Elmer Werner, University of Cincinnati, was elected vice-president.

Second District Physicians To Hold Fall Program in Springfield

At a meeting of Second District officers and delegates in January, Dr. W. P. Montanus, president of the Clark County Medical Society, invited the Second District Medical Society to Springfield for its 1959 annual meeting. The date has been set for Wednesday, October 21, the place to be the Springfield Country Club.

The following preliminary plans for the program have been announced. The afternoon program from 1:30 to 4:30 p. m. will include four speakers as follows:

(1) Dr. George Hamwi, Professor of Medicine and chief of Endocrine and Metabolism Dept. of Ohio State University Medical School, "Various Insulin Preparations and Oral Hypoglycemics."

(2) Dr. Harvey Knowles, College of Medicine, University of Cincinnati, "Problems of Diabetes in the Adolescent."

(3) Dr. Elsie Carrington, Temple University Medical School, Philadelphia, Pa., "Diabetes in Pregnancy."

(4) Dr. Stanley Crawford, Baylor Medical School, Houston, Texas, Associate of Dr. Michael DeBakey, "Vascular Surgery in Diabetes."

A social period will follow the program with dinner at 6:00 p. m.

An evening discussion will include the four afternoon speakers.

Three Research Projects in Ohio Furthered by Foundation

The John A. Hartford Foundation reported that during 1958 it appropriated \$5,585,066, primarily for 66 new or continuing grants to medical institutions, three of them in Ohio. The Ohio projects are the following:

Jewish Hospital Association, Cincinnati, for studies of causative factors of high blood pressure, \$80,000, of which \$39,350 was paid in 1958.

Toledo Hospital, Toledo, for a comprehensive study of leukemia, including a clinical evaluation of a new treatment developed by Toledo Hospital, \$54,025, of which \$39,038 was paid in 1958.

University Hospitals of Cleveland, for metabolic research, \$171,000 of which \$57,000 was paid in 1958.

The Mid-Atlantic Meeting of the International College of Surgeons will be held at the Homestead Hotel, Hot Springs, Virginia, on November 16, 17 and 18. The profession is invited to attend.

Course in Pulmonary Diseases . . .

Ohio State University College of Medicine in Cooperation with Other Professional Groups Sponsors Program in Columbus, September 25-26

FIVE SPONSORING ORGANIZATIONS have joined forces to offer a postgraduate course in pulmonary diseases especially for general practitioners and approved for credit by the Ohio Academy of General Practice. The course is scheduled at Ohio State University in Columbus on Friday and Saturday, September 25-26, 1959.

Sponsors are the Ohio State University College of Medicine, the Ohio State Medical Association, Ohio Trudeau Society, American Trudeau Society, and the Ohio Tuberculosis and Health Association.

Reservations for the course, accompanied by a check for \$25.00 should be sent to: Harold L. Autrey, Treasurer, Ohio Tuberculosis Hospital, Columbus 10, Ohio. Registration is limited to 150 and applications must be received by September 8, 1959.

Hotel reservations should be made with the hotel of choice. The Fort Hayes Hotel has reserved a limited number of rooms until September 8, 1959. (The football weekend makes this early reservation necessary.)

An additional attraction is the Ohio State-Duke University football game on Saturday afternoon, September 26.

The registration fee includes one ticket for the banquet on Friday evening. Extra tickets at \$5 each may be secured for those who wish to bring their wives.

The course has been designed to provide the physician in general practice with current concepts of pulmonary disease, cardiac surgery, and car-

cinoma with emphasis on practical aspects of diagnosis and treatment.

The banquet speaker will be Richard A. Prindle, M. D., Chief of the Air Pollution Medical Program of the United States Public Health Service. He will discuss air pollution.

Other speakers will include James Monroe, M. D., Assistant Director of Ray Brook State Tuberculosis Hospital, Ray Brook, New York, who will discuss "Present Status of Chemotherapy"; Katharine R. Boucot, M. D., Professor of Preventive Medicine, Women's Medical College, Philadelphia, "Detection of Curable Lung Cancer"; George W. Wright, M. D., Head of the Medical Research Department of St. Luke's Hospital, Cleveland, "Pulmonary Emphysema"; and H. S. Van Ordstrand, Chief of the Department of Pulmonary Diseases, Cleveland Clinic, "Differential Diagnosis of Pleural Fluids."

Additional speakers will include members of the staff of the Ohio State University College of Medicine and others.

The program will be held in the Ohio Union Conference Theater, Ohio State University, High Street at 13th Avenue. The banquet will be held in the Gold Room, Fort Hayes Hotel, Columbus.

A group of approximately 20 Western Reserve University School of Medicine students visited Parke, Davis & Company in Detroit on April 27. On April 29 approximately 40 Toledo resident physicians and interns visited the firm.

USE THIS COUPON TO MAKE RESERVATIONS FOR THE POSTGRADUATE COURSE

(Make hotel reservations with the hotel of your choice)

HAROLD L. AUTREY, *Treasurer*
Ohio Tuberculosis Hospital
Columbus 10, Ohio

Please make reservations for the Postgraduate Course in Pulmonary Disease at O. S. U., September 25-26, 1959.

Reservations are for me and for

Please send me also, a banquet ticket for my wife

Enclosed is a check in the amount of

Signed....., M. D.

Address.....

AAPS Essay Contest . . .

Three Seniors From One Warren High School Take Top Honors in Ohio; Essays From More Than 300 Buckeye Students Received for Judging

A UNIQUE feature of this year's essay contest on the American Free Enterprise System and the Advantages of Private Medical Care sponsored by the Association of American Physicians and Surgeons came from Warren, Ohio. There the theme of the contest became a senior high class project in the St. Mary's parochial school of 350 students. The first, second and third place winners in Ohio were all from that class.

Comments by the first place winner, Louis Santucci, tells more of the story: "Having been impressed of the seriousness of the topics of The Advantages of Private Medical Care and The American Free Enterprise System by our sociology instructor, Sister Mary Joseph, S. N. D., the Senior Class took the topics and did extensive and elaborate work in the writing of the essays," he wrote. "Reference material was obtained from the Warren Public Library and the American Medical Association . . . Books, magazine articles and pamphlets furnished us with the information needed.

Did Probing Job

"The panel concerning these topics was made up from volunteer seniors who probed into and explained every single phase of The Advantages of Private Medical Care and the American Free Enterprise System. It was conducted in the presence of the entire senior class, Sister Mary Owen, S. N. D., supervisor of Catholic High Schools and members of the faculty."

The second and third place Ohio winners were, respectively, Patricia Carney and Patricia Teachout.

St. Mary's High School went all out to recognize the contest winners, in cooperation with the Trumbull County Medical Society, and the local Auxiliary, co-sponsor of the contest in the area.

Medical Career Day

The Warren Tribune Chronicle reported the "Medical Career Day" Assembly at which the winners were recognized with a three-column picture and story. Part of that newspaper report follows:

"Dr. Paul Noonan, president of the Trumbull County Medical Association, presented state essay contest awards to Louis Santucci, Patricia Teachout and Patricia Carney at an assembly in St. Mary's High School Thursday (April 23).

"The three senior students entered the local contest sponsored by the County Medical Auxiliary. After winning the top awards in Trumbull County they were eligible to enter the state contest which was sponsored by the Association of American Physicians and Surgeons. They were the top winners in Ohio.

"Richard Flask, president of the school body, introduced the special guests. Guest speaker was Dr. R. W. Juvancic of Girard, who spoke on the trials and tribulations of a doctor, their relationships with the patient and the public, and their moral responsibilities.

"Mrs. H. Ludwig, associate director of the Trumbull Memorial Hospital's School of Nursing, addressed the group on the nursing field and told of the excellent opportunities and various fields that can be entered through the nursing profession.

"Louis Santucci, number one winner in the state, read his winning essay, 'The Advantages of Private Medical Care.' A special vote of thanks was extended to Mrs. John Grima, president of the Medical Auxiliary, and to members of the association for the opportunity to participate in such a contest.

"Plans are being made to set aside one day each year as Medical Career Day at the school. Sister Mary Carl is St. Mary's principal and Sister Mary St. Joseph is teacher of the class."

More Than 300 Ohio Entries

The turn of events in Warren, although unique, is only one phase of the Essay Contest in Ohio. More than 300 essays were received on the top judging level in Ohio alone. The contest is nationwide.

One of the national winners was Miss Dorothy Stafford, Route 1, Howard, a junior at Bladensburg School, who placed 14th in the country and was awarded a \$75 prize for her essay on "The Advantages of the American Free Enterprise System." Contestants were given their choice of that topic or "The Advantages of Private Medical Care."

Dr. George H. Lemon, Toledo, who has been renamed Ohio chairman of the AAPS Essay Contest, has expressed the appreciation of AAPS members to the Ohio State Medical Association and Auxiliary for their cooperation in the contest and to all others who helped promote the program.

Medicare . . .

Bulletin on Handling of Malignancy Cases Is Issued by Department For Information of All Physicians Handling Military Dependent Cases

A BULLETIN of interest to physicians was issued on June 1 by the Office of Dependents' Medical Care (Medicare) Washington. It deals with the management of suspected and/or proven malignancy. Substantial parts of the bulletin is as follows:

Management of Suspected and/or Proven Malignancy

Since the necessity for restricting the Medicare Program, effective October 1, 1958, increasing numbers of cases involving suspected and/or proven malignancy (especially of the breast and cervix) have been brought to the attention of this office. Many of these cases are identified as requiring urgent attention with notations that surgery cannot be planned and that postponement is not advisable or consistent with sound medical practice. These patients frequently are afflicted with a disease process which is not readily visible and often does not produce subjective complaints characteristically associated with other more readily identifiable acute medical or acute surgical conditions.

It is the position of this office that the patient with suspected and/or proven malignancy is an acutely ill patient and qualifies for care under the Program. Many of these patients require immediate hospitalization despite the absence of readily identifiable signs and symptoms. When, in the opinion of the cognizant medical authority, treatment is urgently required, and performed in a hospital without delay, immediately upon discovery of the condition, such care should not be considered plannable. These cases will be considered payable at Government expense when certified by the charge physician in accordance with ODMC Letter No. 6-59, and provided the care is otherwise authorized (i. e., Medicare Permit when required). Such qualifications of urgency cannot be based, for payment at Government expense, on mental anguish, emotional attitudes, or socioeconomic factors involving the patient and/or sponsor, but will be based solely on the medical requirement for immediate hospitalization.

Biopsies

Not Authorized for Payment—It is emphasized that biopsies performed on an outpatient

basis and those services usually considered outpatient care are not payable at Government expense.

Authorized for Payment—Biopsies performed on patients formally admitted to the hospital are payable provided the charge physician indicates the need for hospitalization and states that the biopsy was required to properly manage the suspected, or proven, malignancy which, in his opinion, constituted an acute condition as stipulated in above. In those instances where a Medicare Permit is required for the original admission, an additional Permit will not be required for a subsequent readmission for surgery based upon a positive biopsy report.

Negative Pathological Reports—In some instances, the biopsy report will be "negative." Such care related to the negative biopsy is likewise authorized at Government expense. Subsequent definitive surgery in such instances directed toward these benign conditions is not payable at Government expense.

X-Ray Therapy

X-ray Therapy of Suspected and/or Proven Malignancies—Under certain circumstances the patient, in the opinion of the charge physician, should receive x-ray, radium, or radioisotope therapy rather than surgery. In these instances, it will be necessary that the patient meet the requirements established above, and that the x-ray, radium or radioisotope therapy be prescribed or initiated during a period of hospitalization for authorized care. In this regard, attention is invited to paragraph 2, ODMC Letter No. 3, dated 4 February 1957, which permits use of radiation therapy on an outpatient basis when such care is prescribed or initiated during an authorized period of hospitalization.

Cosmetic Cases Excluded

It is not the intent or purpose of this letter to encourage or infer that payment at Government expense will be authorized for care of warts, nevi, moles, hemangiomas, telangiectatic lesions, keloids, verrucae, condylomata, molluscum, scars, or other similarly recognized conditions when such care is for cosmetic reasons. To be authorized for payment, the claim must be supported by clinical evidence of malignancy and care must have required hospitalization.

Ohio's Mental Hospitals . . .

Special Survey Team Named by Governor Makes Many Recommendations To Improve Facilities and Programs of Institutions Throughout State

RECRUITMENT of "men of stature" in the psychiatric field and "well-trained general practitioners" has been recommended to Governor Michael V. DiSalle by a mental health survey team he appointed to study the state's 25 mental hospitals, and the Division of Mental Hygiene.

The team counted some 90 psychiatrists in the state system plus 200 other physicians on a full or part-time basis. This latter group included specialists of all categories, general practitioners and residents. The team reported, "There is not enough of any category of physician."

Need for Development

It stated that "the skills of the psychiatrists in the state system are being utilized in the best interests of our patients," but elsewhere stated, "It cannot be said that the state has made adequate efforts to develop its psychiatric talents."

Little difficulty in obtaining services of other specialists on a part-time or consultative basis was found in hospitals near metropolitan communities, while those in more isolated areas "have been content with less frequent visits or even going without certain needed specialists."

The team recommended "that the Department (of Mental Hygiene and Correction) determine whether the staffs of all state mental hospitals have adequate representation of the non-psychiatric specialist skills, and that it assist in arranging for procurement of specialists in those hospitals lacking proper specialty treatment programs, and that it make available such monies as are necessary to insure this type of full care to patients in such hospitals."

See Need for More GP's

Commenting that "several dozen" more general practitioners are needed, the team called for a better ratio of patients per doctor. It also said that a large number of the general practitioners are in their late 60's or early 70's, and most will retire in a few years.

"There is also a preponderance of physicians trained in Europe; they are doing a good job in general, but pose special problems in communications."

The team recommended "that the department

develop and pursue a vital and extensive program to recruit general practice physicians for employment in Ohio mental hospitals."

Residency Program Praised

It described the residency program as "a bright spot," and called for a program and staff to attract more residents. Also, the use of part-time psychiatrists to supplement the regular staff was advised. It called for the state to finance psychiatrist participation in national professional societies, and stimulation of research.

It specifically recommended "that it be departmental policy that each full-time member of the medical staff of each state hospital with the approval of his hospital superintendent be given time off duty and a reasonable expense allotment to attend a meeting of the professional society related to his work once in each three-year period, and that each superintendent and one psychiatrist designated by him and approved by the division be given time off duty and a reasonable expense allotment to attend the annual meeting of the American Psychiatric Association each year, and that each medical staff member be given time off duty with no expense allocation to attend a related professional meeting in each other year.

Research

"In regard to research, it is recommended that it be departmental policy for an advisory committee to the Bureau of Research to be established, having representation from the state mental hospitals and other state or private research organizations, and that this committee assist the Bureau in stimulating, evaluating, financing, coordinating, and aiding research projects in the state mental hospitals."

The report called for more internal training to stimulate staff development, including seminars, lectures and short courses, stating:

Refresher Work

"Physicians on the staff of all state mental hospitals should be actively encouraged to take part in meetings of the local medical society. There is no reason why state doctors should feel either unneeded or unwanted at such meetings. Failure to participate has perpetuated the improper lack

of communication with other physicians in the community. Much good can come of such relationships."

In the in-service training category, the committee recommended "that the department supply leadership in working with the state mental hospitals to develop intra-hospital and inter-hospital training activities for the medical staffs of the hospitals, that it develop a Short Course at the Psychiatric Institutes for staff members from other state mental hospitals, and that it encourage participation by such members in local medical society activities."

Committee Needs Cited

The department was advised to require better committee organization. Noting that only three—Hawthornden, Columbus State and Cleveland Psychiatric—have extensive committee organization, the committee called for development of a list of committees to be required in each of the 25 mental hospitals.

It concluded the medical staff section of the report by calling for development of procedural manuals for physicians and improvement of medical libraries.

Nursing

The section of the report pertaining to nursing criticized what the team described as lack of centralized authority, and cited cases where attendants to the physically ill refused to carry out orders from a nurse because they were not under nursing authority.

The group called for a departmental policy whereby each hospital designate a registered nurse as director of nursing service, responsible to the superintendent, and with subsequent responsibility for "maintenance and improvement of nursing services and the supervision, management, assignment and training of all nursing personnel."

It also called on the department's central office to prepare a guide for development of nursing policies and procedures. It recommended that each institution should have a "written and enforced procedure" in reporting and follow-up of incidents such as patient attacks on personnel. Also, the department was asked to direct each hospital to establish a committee on improvement of patient care.

Attendants Praised

Describing the attendants as "the backbone of the mental hospital system," the report noted that while many of the attendants contributed considerably to the program, "some bad attendants" kept their jobs "only because of the protection

given Civil Service employes by the Civil Service Board of Appeals."

The report cited a "clearly documented case of an attendant drunk on duty who was suspended by the superintendent but ordered back to employment by the (Civil Service) Appeals Board."

The team commented that "isolated instances will arouse public opinion and create a public image of horror, but the public does not know of the attendants who buy Christmas gifts for 60 patients, buy toasters because the state has not supplied them, take patients out for movies, treat them as their own children, have their sons and daughters and grandchildren become attendants, etc., etc." It called for a research program to improve the contribution attendants can make.

Practical Nurses

Also recommended was recruitment of licensed practical nurses to help offset the shortage of registered nurses, thereby releasing them "for duties requiring their greater skills." The team stated, "We can only conclude that staffing is not adequate and that a considerably larger number of nursing personnel must be added if we are to provide more than custodial care in our large hospitals."

Commending the nurse training program whereby some 250 student nurses are sent to the hospitals for psychiatric training each year, the survey unit recommended that the department actively seek to increase the number of nursing schools participating in the program.

Patients Need Segregation

In the realm of patient care, better segregation was recommended in all lines. Criticized was the inter-mixing of various age groups. Segregation of the aged, seniles, and the incontinent was recommended because each of these groups has a particular care problem.

The team said that in the prolonged stay hospital medical records were "usually mute testimony to the lack of individualized attention the patient has received," and called for a requirement that a doctor periodically enter on the records progressive notes "to insure that the doctor had at least undertaken some study of the case."

Infections Committee

Referring to the national program of prevention of spread of staphylococcus and streptococcus infections in general hospitals, the report called for a department requirement that each hospital have an infections committee, and that copies of minutes of each committee's meetings be forwarded to the commissioner of mental hygiene.

It also called for effective emergency summons

systems and for safeguards in medication procedures. The committee also deplored crowding of beds side by side in some of the institutions.

Laboratories Criticized

The team described the overall laboratory work as "the weakest link in the medical armamentarium of our mental hospitals." It said there was a lack of uniform standards, frequent lack of periodic examination of food handlers and a "seeming lack of interest in the physical health of patients as is demonstrated by the paucity of laboratory examinations."

It called for the department to "develop, publish and enforce" minimum standards for laboratory studies of new patients, long-stay patients, new employees, and periodic re-examination of all employees and employee and patient foodhandlers.

More pathology study of surgical tissue was requested, as was more autopsy study, although Columbus State Hospital was commended for its 75 per cent autopsy rate.

The team reported that electroencephalography, "a real specific tool for the psychiatrist" was never used at some hospitals, used little at others, and considered highly important at some. It attributed the former to "lack of staff interest in this matter."

X-Ray Facilities

In the X-ray field, the team said there appeared to be "satisfactory work" and satisfactory radiography and fluoroscopy units, although Lima State Hospital was criticized for having its X-ray in a department that is not lead-lined.

In pharmacy, the report concluded that only half of the hospitals "have a formulary for drug standardization; as a further evidence of lack of interest by the administration and medical staff, only a few have pharmacy committees to improve and standardize drugs and procedures." It recommended that each hospital be required to establish an active pharmacy committee.

Tranquilizers Studied

In its study of the use of tranquilizers, the survey team reported that two-thirds of the hospitals expressed a need for more such drugs.

However, it added that from studies of the question, "it appears that additional ataractic drugs of approximately only 10 per cent are needed."

Dental Program

The dental care was criticized as "half-done," with increased salaries to attract more personnel in the dental field held out as a partial answer.

"The dental situation is distressing," the committee concluded.

It also called for the state to provide dental plates and eyeglasses at state expense for patients who need them but cannot afford them. The same recommendation was made for orthopedic braces.

Additional Recommendations

Among the many miscellaneous recommendations in the report were the following:

That the department study the feasibility of providing drugs to medically indigent discharged patients or to patients on trial visit who are medically indigent, and consider the possibility of referral to private practice physicians where indicated, so as to improve follow-up and reduce re-admissions.

That the department develop, for submission to the Legislature, a program to provide grants-in-aid to general hospitals for the construction of psychiatric units, and a program to reimburse general hospitals for the cost of care rendered to mentally ill patients who are medically indigent.

That the governor appoint a research commission to determine a feasible method of fulfilling the state's responsibility for providing care and treatment to citizens suffering from alcoholism.

Study Personnel

Jay W. Collins, executive director, Euclid-Glenville Hospital, was director of the mental health survey team. In a covering letter accompanying the report to the governor, Mr. Collins said, "Many of the answers offered in this report could have been supplied by others throughout the years. They should have been. The excuses of 'no money and no staff' are justified in some instances, but do not explain dilatory approach to a mass of other problems. There has been improvement in the past few years, but we cannot wait for evolution.

"The recommendations in this report are neither theoretical nor are they inclusive, nor are they the only answers. They are presented as things which can be done and should be done now."

Other Team Members

Other team members included Elizabeth Perry, director, management food service hospital division, Stouffer Corporation, Cleveland; Mary McKelvey, director of Dietetics, Christ Hospital, Cincinnati; Rosemary Brown, director of dietetics, Toledo Hospital; Mary DeMarco, director of dietetics, Cleveland Metropolitan General Hospital; Mary Letherman, executive dietitian, Mount Carmel Hospital, Columbus;

Frederick H. Wescoe, R. N., administrative di-

rector of nursing, Jewish Hospital and Medical Center, Cincinnati; Dorcas Crossman, R. N., director of nursing, Flower Hospital, Toledo; Mildred E. Feinauer, R. N., chief of nursing service, Crile VA Hospital, Cleveland; Georgiana Ochs, R. N., director of Nursing Service, City Hospital, Springfield;

Earl J. Williams, chief engineer, Mercy Hospital, Portsmouth; Edward K. Gilmore, chief engineer, St. Luke's Hospital, Toledo; Paul C. Wilson, plant and maintenance superintendent, Grant Hospital, Columbus; Robert W. Loeb, maintenance superintendent, Miami Valley Hospital, Dayton; George V. Laster, supervisor of buildings and grounds, Mt. Sinai Hospital, Cleveland;

Henry N. Hooper, administrator, Cincinnati General Hospital; Wilson L. Benfer, Administrator, Toledo Hospital; David A. Endres, superintendent, Youngstown Hospital Association, and Frank C. Sutton, M. D., director Miami Valley Hospital, Dayton.

Other hospital categories covered in the report included social service, occupational and recreational therapy, dietary, maintenance, laundry, housekeeping, business office, personnel, religion, community relations, patient labor, management, as well as comments on the Department's central office, on alcoholism and state laws pertaining to admission of patients.

AMA Committee Reports Use, Effect of Amphetamines In Sports Minimal

A poll of 1,548 college and high school coaches showed that less than one per cent admitted use of amphetamines in athletics, a special AMA committee has reported.

The committee also reported that two double blind studies indicated that amphetamines can artificially improve performance.

The committee, headed by Allan H. Ryan, M. D., Meriden, Conn., reported finding "little concrete evidence" to support an allegation before the 1957 AMA House of Delegates that amphetamines were widely used in athletics.

Controlled studies of the effect of amphetamines showed they artificially improved ordinary performance in athletes, ranging from three to four per cent in shot-putting, 1.5 per cent in running, and 0.59 to 1.16 per cent in swimming.

The committee noted that sugar-type pills and vitamins were in relative common use, and sometimes were labeled "pep" pills.

WHAT TO WRITE FOR

Some booklets, pamphlets and other published material available for the asking or at nominal expense and suitable for the physician's office, library or waiting rooms, or for his personal information.

* * *

List of Worthwhile Health Insurance Books. Bibliography lists health insurance books, publications, periodicals. Chapters deal with general insurance, gerontology, social security, research, and lists national organizations having a relationship to the task of financing medical care costs. Write Health Insurance Institute, 488 Madison Avenue, New York 22, N. Y.

* * *

Fungus Infections. This bibliography on systemic and superficial fungus infections is the latest in a series. Others in the series include space medicine, cancer chemotherapy and staphylococcal infections. Write Acquisition Division, National Library of Medicine, Seventh Street and Independence Avenue, S. W., Washington 25, D. C.

* * *

Taking Care of Diabetes. Prepared for the diabetic patient and his family. Discusses diabetes, insulin, urine testing, care of the feet, insulin reactions, diabetic coma, meals, eating away from home, and provides food exchange lists. (20 cents) Write Superintendent of Documents, Government Printing Office, Washington 25, D. C.

* * *

How to Bandage for Faster Healing. Booklet shows step-by-step illustrations of proper procedures for treating and bandaging minor injuries, and first aid items recommended for home medicine chests. Write Johnson & Johnson, New Brunswick, New Jersey.

* * *

The Patient Asks for a Medical Report. Explains for those who keep medical records how to prepare a medical report for a patient's claim under disability provisions of social security law. (five cents) Write Superintendent of Documents, Washington 25, D. C.

* * *

The Recognition of Lead Poisoning in The Child. Written for the practicing physician, this pamphlet deals with incidence, etiology, diagnosis and treatment of the subject. 10 cents. Write Superintendent of Documents, Washington 25, D. C.

OUT OF THE BLUE

By R. DEAN DOOLEY, M. D., Director
Physicians' Relations Department
Ohio Medical Indemnity

The National Conference of Blue Cross and Blue Shield Plans was held in Miami Beach, Florida, the last week in April. Three activities were emphasized as being vital to the future of the voluntary prepayment movement:

1. The absolute need of a workable plan for the 65 and above age groups;
2. The need of a more dynamic professional relations program;
3. A public relations program to tell the human side of the practice of medicine.

There can be no disagreement with respect to the worth of these objectives—all are important and all must be implemented. You quite correctly may ask the question, "What is OMI doing to achieve these objectives so important to our welfare"?

The staff in concert with committees from the board has been working on the program for the aged and is in a position to render assistance to the OSMA in this matter.

The professional relations department has been organized and is under the direction of this writer. We shall endeavor to acquaint you with Ohio Medical's program, its objectives and its impact on the future course of organized medicine. We hope to personally present our story to as many physicians as possible before county societies, hospital staffs and specialty groups.

As yet, we do not have an organized department of public relations. Dr. Mayfield in his inaugural address to the House of Delegates of the OSMA, stressed the need for close cooperation with the press, so that our story may be appropriately portrayed to the public.

The medical profession occupies a unique position in our society in that the act and actions of each physician is a contribution or a liability to our public relations program. The physician in the day-to-day conduct of his practice possesses tremendous potential in the building of favorable public acceptance for his profession.

Indeed, we are going forward, determined to keep our program in step with the changing times to better serve our subscribers and you, their physicians.

Dr. Arthur H. Bill, retired head of the Western Reserve University School of Medicine's Department of Obstetrics, received an honorary Doctor of Science degree at Marietta College in June.

Find Intern Is Chiropractor; Bounced from Staff

The following is from an article published in the May 12 issue of the *Cleveland Plain Dealer*:

A California chiropractor in training for an Ohio physician's license was fired suddenly last night from the intern staff of St. Alexis' Hospital.

George Chromiak, Jr., was given until midnight to leave the hospital grounds after he failed a quiz into his medical background, according to Dr. W. F. Boukalik, hospital chief of staff.

Chromiak, 55, had been employed here as an intern at \$200 a month since last summer. As credentials he cited diplomas from a Mexico City institution no longer in existence and a license to practice medicine and surgery in Maryland.

The Maryland license, issued in 1956, was signed by Dr. Robert H. Reddick, who is now serving a penitentiary term for selling medical licenses for as much as \$5,000 each. An inquiry of Maryland authorities brought a reply that there was no record there of a license issued to Chromiak, according to Dr. Chester R. Jablonoski, president of the Academy of Medicine of Cleveland.

Chromiak said he got his license legitimately on the strength of the Mexican education completed 14 years before.

Chromiak has led medical authorities a merry but slow cross-country chase, according to the files of the American Medical Association. The fact that he had been employed here was routinely reported to the AMA last July and nothing came of it until two weeks ago, when a local check into his background was begun on a tip from the AMA.

He has served internships in various hospitals elsewhere, including Buffalo, N. Y., and Trenton, New Jersey.

AMA records gleaned from official files have Chromiak studying at various chiropractic schools at the same time that he supposedly was earning his medical diplomas in Mexico.

He was licensed in chiropractic in Michigan in 1939 and in California in 1941 after studying since 1935. At the same time he claimed attendance at the Mexican school from 1938 to 1942.

"I went to chiropractic school in summer," Chromiak explained.

Dr. Austin Smith, former editor of the *Journal of the AMA*, is now chief executive officer of the American Pharmaceutical Association, an organization of manufacturers of prescription products which was recently formed by merging the American Drug Manufacturers Association and the American Pharmaceutical Manufacturers' Association.

New Gains in Health Insurance Coverage Reported

The proportion of American families covered by voluntary health insurance is still increasing, Health Information Foundation reports. Recent gains in enrollment have been most rapid among a group once considered "uninsurable"—persons 65 or older.

In its monthly bulletin, *Progress in Health Services*, the Foundation said that 69 per cent of all U. S. families now have at least one member protected by some form of health insurance—an increase of almost 10 per cent since 1953 in the proportion of families covered.

The Foundation published preliminary results of a survey made in cooperation with the National Opinion Research Center of the University of Chicago. A representative cross-section of American families were interviewed at length in 1958 about such questions as what types of medical services they obtain, how they pay for medical care, and what kinds of health insurance they carry.

Although coverage under voluntary health insurance increased for all age groups from 1953 to 1958, the Foundation said that the rise was especially notable for persons at the older ages. There was an increase of almost 40 per cent in the proportion of persons 65 or older with health insurance.

According to George Bugbee, Foundation President, recent experience with insuring the aged "offers encouraging proof that at least one group once considered 'uninsurable' can be reached in sizable numbers."

During the five-year survey period, the proportion of individuals with hospitalization insurance increased from 57 to 65 per cent of the total population, and the proportion with medical-surgical coverage rose from 48 to 61 per cent.

Current estimates indicate that in five of the most densely populated states—Connecticut, Ohio, New York, Pennsylvania, and Illinois—85 per cent or more of the population is enrolled under some voluntary plan.

Heart Research Grants

Applications are now being accepted by the American Heart Association for support of research to be conducted during the fiscal year beginning July 1, 1960.

September 15, 1959, is the deadline for applying for Research Fellowships and Established Investigatorships. Applications for Grants-in-Aid must be made by November 1, 1959. Details may be obtained by writing: The American Heart Association, 44 E. 23rd St., New York 10.

Scholarship Established for Deserving Medical Students at Ohio State

A medical scholarship at Ohio State University has been created through the estate of the late Dr. Paul J. Alspaugh, formerly of New Philadelphia, and his sisters Gertrude and Maude L. Alspaugh, who made their home at Canal Winchester.

Dr. Alspaugh graduated from Starling Loving Medical School, Columbus, in 1906. He practiced for some time at Massillon State Hospital and at the time of his death was practicing at New Philadelphia.

Executor of the estate and the scholarship is Dr. D. J. Alspaugh, a cousin of Dr. Paul Alspaugh and his sisters.

The net amount of the fund is \$32,137.22. The principal is to remain constant and only interest from the amount is to be used for the perpetual scholarship. In this way, an unmarried deserving student in each class will be granted a scholarship amounting to about \$500 a year for the four year period, providing that grades and moral standards satisfy the committee throughout the period.

A deserving student will be selected by a committee composed of a representative of the Scholarship Committee, a representative of the College of Medicine, and Dr. D. J. Alspaugh or his designee. The scholarship will start at the beginning of the fall term of 1959-60 if a deserving student is selected.

Cleveland—Dr. Bruno Gebhard, Cleveland, is attending the Fifth Meeting of the International Council of Museums (UNESCO) in Stockholm. He will report to the Committee on Scientific and Technical Museums on "Experiences with Health Museums in the U. S. A. 1940-1959." Also, Dr. Gebhard, who is director of the Cleveland Health Museum, has been invited to consult with the Preparatory Committee on a Health Museum in Stockholm.

Youngstown—Sidney Franklin, M. D., LL. B., addressed the annual convention of The American Board of Legal Medicine on the subject of "Air Pollution and the Law" at Atlantic City, on June 7 and was elected second vice-president of the Board.

Drs. Woodhouse and Phillips Honored by Ohio U.

Among those who received the Certificate of Merit of the Ohio University Alumni Association on June 6 for distinguished service in the medical profession were Dr. George A. Woodhouse, Pleasant Hill, immediate past-president of the Ohio State Medical Association, and Dr. Fred W. Phillips, Zanesville surgeon.

Medical Education . . .

AMA Executive Vice-President Outlines Growth in Training of Doctors; Increase in Facilities of Medical Schools; Other Data on Medical Schools

A PERTINENT picture of the number of physicians being trained and the growth in medical schools is drawn by AMA Executive Vice-President F. J. L. Blasingame, M. D., in reply to an inquiry from U. S. Representative Clark W. Thompson of Texas.

Rep. Thompson had placed in the April 23 *Congressional Record* Dr. Blasingame's entire letter, which reads as follows:

AMERICAN MEDICAL ASSOCIATION
Chicago, Ill, April 16, 1959.

HON. CLARK W. THOMPSON,
*House Office Building,
Washington, D. C.*

DEAR CONGRESSMAN THOMPSON: Thank you for your recent letter and your interest in medical education.

It is indeed a pleasure to bring you an up-to-date report on the status of medical education in the United States. As you know, I am proud of the accomplishments of our medical schools and have great faith in their ability to train enough physicians to meet the needs of our growing population.

You asked seven important questions about the medical education picture. Let me answer them one by one.

First, has the number of physicians graduated from approved medical schools kept pace with the growth of the Nation's population? Over the long haul, the increase in medical graduates is much greater proportionately than is the increase in the population. From 1920 to 1958, the percentage of increase in medical graduates from approved schools was 125 per cent, compared with a 64-per cent increase in population. In the past 20 years, the percentage figures are fairly comparable: 32.1 per cent increase for medical graduates; 33.4 per cent increase for population.

The future, I believe, looks bright. Each year, for the past 11 years, the number of students enrolled in approved medical schools has increased. This boost in enrollment amounts to 29.6 per cent (from 22,739 to 29,473).

Your second question was whether medical schools seek to restrict the number of medical students. Two factors make it necessary for a school to establish an arbitrary top enrollment fig-

ure: facilities and budgetary funds available to operate the school. Each school faculty determines the number of students who can have a sound education with the faculty personnel and the facilities available to the school.

Medical education is a graduate educational experience following the completion of the regular college course, and because of the subject matter covered requires individual and small group instruction. To turn out well-trained, highly-qualified physicians the school requires a large faculty of skilled educators, plus sufficient teaching and research laboratories, hospital beds and clinical patients. The number of students that can be taught must be necessarily restricted to fit the facilities so that the emphasis can be on quality of the graduate rather than on the quantity of students.

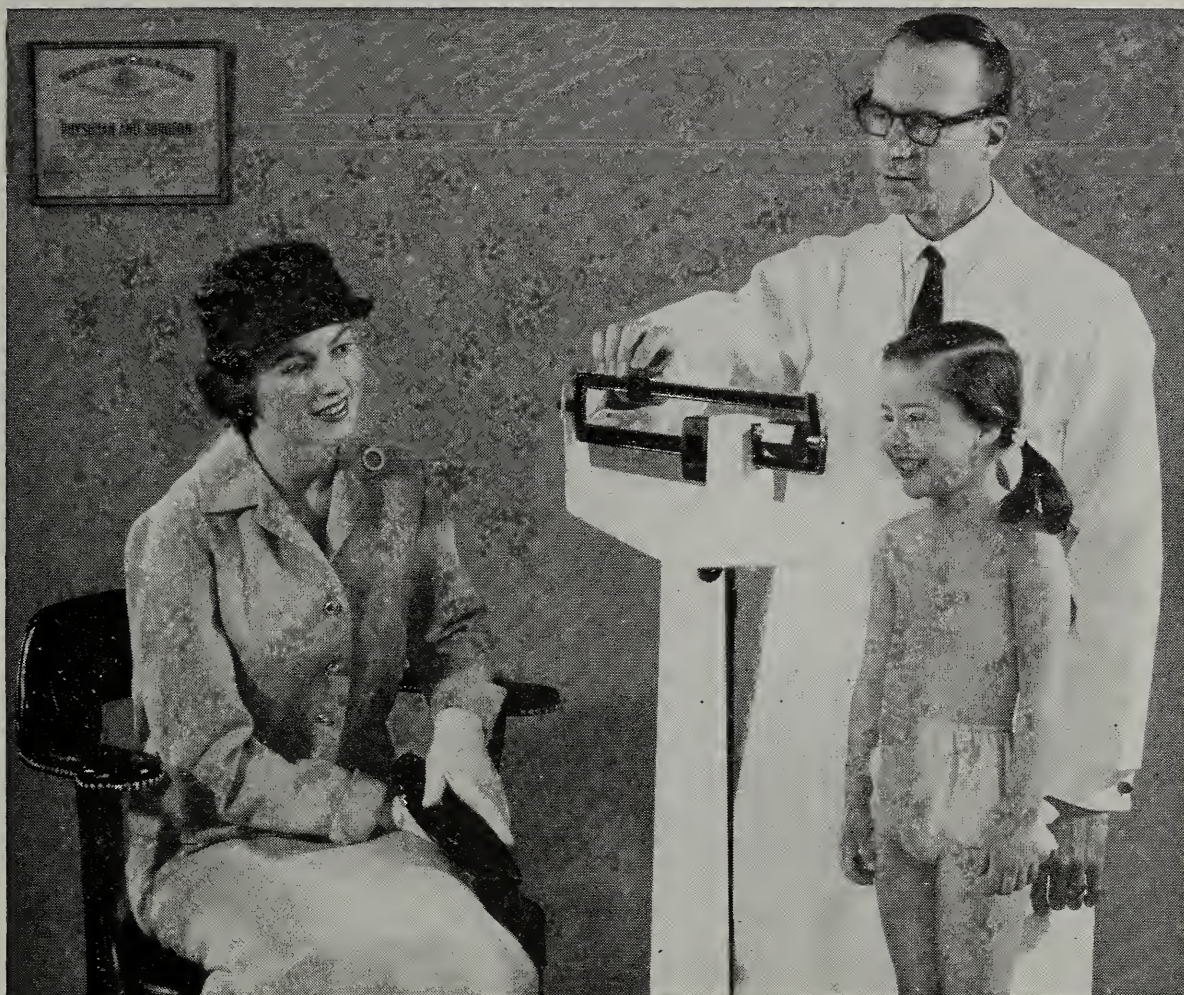
Third, you asked: What is the ratio between applicants to medical schools and those accepted? The answer is 1.97 (15,791 applicants for first year medical school to 8,030 places available). This ratio has remained about the same for the past 5 years.

Incidentally, a common confusion that arises in discussing applicants to student ratio is mistaking applications for people (applicants). Each person applies, on the average to four medical schools. Thus, for the 1957-58 academic year, the 15,791 applicants filed a total of 60,946 applications.

Next, you asked if it is true that only students with an A college academic record are accepted into medical school. That has never been true. About one-sixth of the entering medical students for the whole country have A college records; about two-thirds have B records and about one-sixth have C records.

Your fifth question was: Is the number of medical schools increasing in the United States? In 1944, there were 77 approved medical schools, including eight 2-year schools from which students had to complete their final 2 years of medical education in any of the 69 4-year schools. In 1958, there were 85 approved medical schools. Eighty-one are 4-year schools; only four 2-year schools.

Two other schools are under development. As a step toward still further expansion of medical school facilities, the American Medical Association



Underweight Children Gain and Retain Weight with Nilevar[®]

One of the most convincing evidences of the anabolic activity of Nilevar, brand of norethandrolone, has been its ability to improve appetite and increase weight in poorly nourished, underweight children.

A highly important feature of the weight gain thus produced is that it is not ordinarily manifested by deposition of fat but as muscle tissue resulting from the protein anabolism induced by Nilevar.

Anorexia and "Weight Lag" Study—Brown, Libo and Nussbaum have reported* consistent and definite increases in rate of weight gain in eighty-six patients, ranging in age from 7 weeks to 15½ years. This beneficial action of Nilevar was observed in the patients with organic and traumatic disorders as well as those whose only complaints were poor appetite and/or persistent failure to gain weight.

In this study, the weight gained was not lost

after discontinuance of Nilevar therapy although many patients did not continue the sharp gains effected by the drug.

The authors are of the opinion that Nilevar is a highly useful anabolic agent for influencing weight gain in underweight children.

When Nilevar is administered to children a dose of 0.25 mg. per pound of body weight is recommended and continuous dosage for more than three months is not recommended.

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G. D. Searle & Co., Chicago 80, Illinois.
Research in the Service of Medicine.

*Brown, S. S.; Libo, H. W., and Nussbaum, A. H.: Norethandrolone in the Successful Management of Anorexia and "Weight Lag" in Children, Scientific Exhibit presented at the Annual Meeting of the American Academy of Pediatrics, Chicago, Oct. 20-23, 1958.

last year urged "institutions of higher education where medical education has not been undertaken in the past to give serious consideration to the development of opportunities in the field."

Sixth, Has the American Medical Association anything to do with the number of enrollments in medical schools? Enrollments are strictly determined by each individual medical school. Neither the universities nor their medical schools would permit an intrusion into their academic freedom by a national professional association.

Your final question asked whether I think it is necessary for Federal funds to be provided for medical schools. The medical profession welcomes one-time Federal grants for medical school construction and renovation as well as Federal grants for basic research. The profession has been opposed to continuing Federal aid for operating expenses because of the potentialities therein for Federal control.

I should like to point out that the National Fund for Medical Education, which raises funds from industrial sources, and the American Medical Education Foundation, which raises funds from the medical profession, have made grants in excess of \$10 million to medical education over the past 8 years.

I hope this information will aid you in analyzing bills introduced in the 86th Congress which pertain to the training of physicians. As further background, I am sending along a copy of the most recent annual report prepared by our council on medical education and hospitals, which was published in the *Journal of the American Medical Association*, November 15, 1958. It provides additional data that you might find useful.

I am happy that you wrote me after conferring with our mutual friend, Dr. John Truslow. If I can provide any additional information, please make your wishes known.

Sincerely yours,

F. J. L. BLASINGAME, M. D.

* * *

License Almost 8,000 New Doctors During 1958

Almost 8,000 new physicians were licensed to practice medicine in the United States during 1958, it was reported by the American Medical Association's Council on Medical Education and Hospitals.

In its 57th annual report, which appears in the May 30 *AMA Journal*, the council said that this marks the sixth consecutive year in which more than 7,000 new physicians were licensed.

Of the 7,809 new doctors, 6,155 were licensed

through written examinations and 1,654 by endorsement of credentials.

During the period, there were approximately 3,700 physician deaths reported to the AMA, which reduces the over-all gain in the doctor population to 4,109.

In all, 15,240 licenses to practice medicine were issued in 1958. Written examinations accounted for 7,315 licenses and 7,925 were given through reciprocity and endorsement of credentials.

Of these, California issued the greatest number—2,205. New York was next with 1,584. Illinois, Ohio, Pennsylvania, and Texas each registered more than 500 doctors.

The State Medical Board of Ohio reported that during 1958 it issued licenses to 398 doctors of medicine by examination and to 339 by endorsement—a total of 737 M. D.'s. In addition, licenses were issued to 65 osteopaths by examination and to 9 by endorsement.

The State Medical Board gives examinations twice a year—in June and in December, but the licensing of those who take the December examinations runs over into the next year.

The Ohio State Medical Journal reported the deaths of 228 physicians in 1958. This figure includes some former Ohio physicians who were residing in other states at the time of death and a few physicians from other states who were residing in Ohio at the time of death.

Nine states—Alaska, Delaware, Idaho, Montana, Nevada, North and South Dakota, Vermont and Wyoming—issued less than 50 licenses during the year. Among the territories and possessions, Puerto Rico licensed 107, Hawaii 44, Canal Zone 6, Guam and the Virgin Islands two each.

The council said there was an increase of 104 in the total number of licenses issued in 1958 over the previous year.

During the year there were 8,633 applicants for licensure by written examination. Of these 7,268 passed and 1,365 failed.

Among those examined were 5,692 graduates of approved medical schools in the United States, 168 from Canada, one graduate of an approved medical school in the U. S. which is no longer in operation, 2,567 from foreign schools, 25 graduates of unapproved medical schools in the U. S. which are no longer in existence, and 180 graduates of schools of osteopathy.

The Columbus Dispatch devoted seven columns to an illustrated feature story on Dr. Maurice Rarick on the occasion of his 80th birthday. A native of the Buckeye Lake area, Dr. Rarick has served most of his professional career in that vicinity.

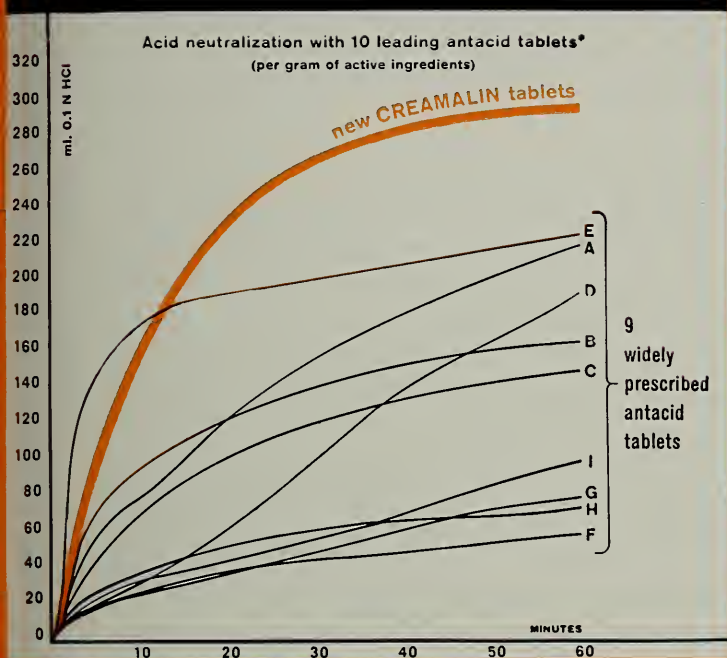
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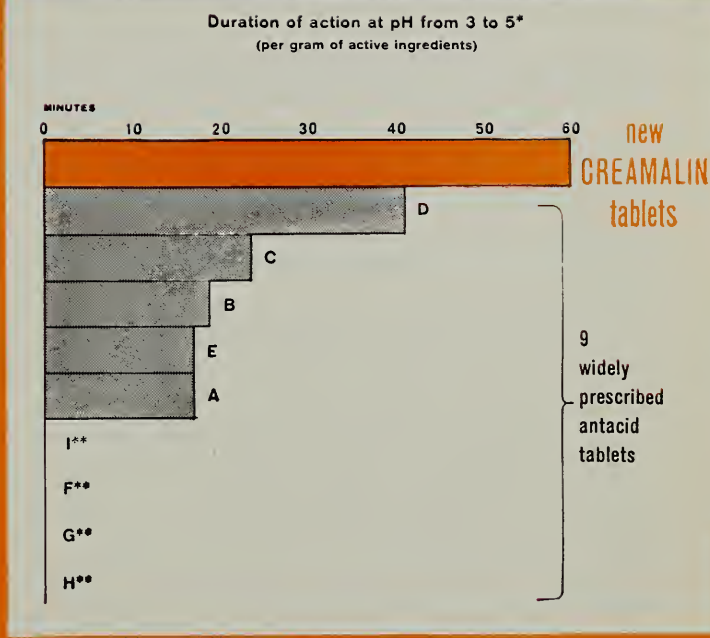
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*Hinkel, E. T., Jr., Fisher, and Tainter, M. L.: A new highly reactive aluminum hydroxide complex for gastric hyperacidity. To be published

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Use of Health Services by the Aged . . .

How Often Do Older People Visit a Doctor? Why Do Some Not Consult a Physician? How Do They Pay the Bill? Survey Throws Light on Subject

THE aged inevitably face special health problems, for with advancing age comes a decline in health and physical capacity. This often results in an increased burden of disability and dependency as well as a need for more than the usual number of medical services, personal and nursing care, hospital services, and appliances.

Some 1,700 persons aged 65 and over, a random cross-section of the country's aged population (except those in institutions), were interviewed at length in 1957 about their health, living arrangements, income, and other items. The data presented here are based on preliminary tabulations of the information supplied by those interviewed.

Persons 65 and over in this country were averaging 7.6 annual out-of-hospital contacts with doctors in 1957. This figure runs close to the 6.8 annual average for persons 65 and over reported for 1957-58 to the National Health Survey. It exceeds by roughly 40 per cent the average of 5.3 for the entire population.

The average for women in this study, 8.4, was about 25 per cent higher than the average for men, 6.7. Over two-thirds of all out-of-hospital contacts with a doctor (5.2 annually, 69 per cent of the total) took place in the doctor's office. Smaller proportions occurred at home (22 per cent), in a clinic (7 per cent), or over the telephone (2 per cent). Visits at home and telephone contacts constituted higher proportions of total doctor contacts for women than for men, while clinic visits were relatively more important in the total for men.

Recent Contact with Doctor

Just over one-fourth of the respondents, 27.3 per cent, had some contact with a doctor outside of a hospital during the four weeks before the interview. The per cent for women, 30.2, was above the corresponding figure for men, 23.8.

More than seven out of every ten respondents, however, had no contact with doctors during the four-week period. Of these, one in five had no health complaint or illness during the four weeks. But the remaining four-fifths, 80 per cent (58 per cent of the total sample), had some

EDITOR'S NOTE:

Persons aged 65 and over constitute a substantial segment of the United States population, and a good proportion of the average physician's practice. Their number is increasing. How often and under what circumstances the aged use medical services and facilities thus becomes an important subject for research.

This article is a report of some of the data obtained from a study of the aging in the United States, made under the direction of Ethel Shanas, Ph. D., senior study director of the National Opinion Research Center, University of Chicago in cooperation with the Health Information Foundation.

health complaint or illness, yet for various reasons did not seek treatment.

The most frequent reason given by older people for not seeing the doctor was that their health complaint was minor. This reason was mentioned by 44 per cent of the persons with a health complaint yet not seeing a physician (19 per cent of the total sample). Another 27 per cent (12 per cent of the total sample) voiced a lack of confidence in the ability of a physician to help them. Only 6 per cent (about 2 per cent of the total sample) said they lacked the money to see a doctor. No reason was given in 22 per cent of the cases.

Among those with some doctor contact in the last four weeks, 1.2 per cent of the sample made their only contact by phone. But for the remainder of those with out-of-hospital contact (26.1 per cent of the sample), the visit took place either in the doctor's office, the respondent's home, or a clinic.

The largest proportion, 22.2 per cent of the total sample, saw the doctor at his office, while 6.4 per cent were visited at home and 2.4 per cent saw the doctor at a clinic. For persons making these non-telephone out-of-hospital visits, most (23.8 per cent of the total sample) saw one doctor, but 2.3 per cent saw several. Somewhat over half of those whose contact was in the office, home, or clinic saw a doctor only once in that specific place during the four weeks. A

smaller proportion had two visits, and about one in five had three or more visits in any of these places.

About one in four persons among those seeing a doctor in the office, home, or clinic did so because of diseases of the circulatory system (especially diseases of the heart and hypertension without mention of heart disease). This broad category of illness was the most frequently mentioned. Another reason given, especially by those who had made office visits, was simply the presence of "symptoms" (most often affecting the limbs or back), or other ill-defined conditions. In addition, respiratory conditions accounted for a sizable proportion of those whose doctor visits were at home, and "check-up" for those who saw a doctor at the clinic.

Paying the Doctor

Most aged persons who had seen a doctor outside a hospital in the past four weeks (or had talked with one over the phone) paid for the service—or would pay in the near future—out of their own pockets. The proportion paying was 71 per cent of those with doctor contact (19 per cent of the total sample). About one in five of those with doctor contact did not make any out-of-pocket payments. Information was unavailable from one in twelve respondents with doctor contact, while less than 1 per cent paid some doctors but not others. A small proportion of those paying for doctor visits—9 per cent—could not report an amount of payment, either because they had not yet received a bill or for other reasons.

Among those reporting an amount, the mean average billed or already paid, covering the four-week period, was \$12.26. But this average conceals a considerable variation. For example, 26 per cent of those reporting an amount gave it as between \$1 and \$4, and an additional 32 per cent specified \$5 to \$9. At the high extreme, 5 per cent of those reporting an amount specified \$30 to \$49, while 2 per cent mentioned \$50 or over for the four-week period.

Among those making out-of-pocket payments for doctor bills incurred during the last four weeks, most persons aged 65 and over said they had paid or would pay all or part of these bills themselves—through income, savings, or in some other way. About two-thirds, 68 per cent (13 per cent of the total sample), met all or part of this out-of-pocket expense out of their income, while about one in five, 21 per cent (4 per cent of the total sample), used savings, and 2 per cent met them in some other way. Among those using

their own resources, one in twelve, 8 per cent, depended on a child or other relative for assistance, and 1.5 per cent on someone else.

Persons who did not pay the doctor for contacts in the four-week period fell into two major and several minor categories. About three in eight persons not paying for contacts, 37 per cent (but only 2 per cent of the total sample) were not charged by the doctor for their visit. Among the reasons given for free care were these: The contact was only by telephone and the doctor doesn't charge for telephone calls; the patients were members of the doctor's family, or his personal friends; they received "professional courtesy" for being either another doctor or a minister.

For 36 per cent of those who did not make out-of-pocket payments, doctor bills were paid by a welfare or charitable agency. Less frequent reasons were: There were charges, but the bills were covered by insurance, 14 per cent of those not paying for doctors' services; their past or present employer paid, 5 per cent; they received veterans' care, 2 per cent; and the fee was included as post-operative care by the doctor, 2 per cent.

Long-Term Habits of Seeing the Doctor

Including telephone contacts during the previous four weeks, nearly two-thirds, 63 per cent, of the aged, had seen or consulted a doctor about their health within a year preceding the survey. (This per cent is almost the same as reported for the entire population in other surveys.) The proportion was higher for females aged 65 and over, 67 per cent, than for males, 59 per cent.

In addition to those whose last visit was within the year, an additional 22 per cent had last seen a doctor within one to four years. Another 10 per cent had not seen a doctor in five years or more, while for 5 per cent the data were indeterminate.

Most of those who had seen a doctor at any time in the past (excluding visits in the previous four weeks) last saw him about a specific health complaint. This category accounted for 55 per cent of the last visits to the doctor made by the respondents. In addition, 13 per cent saw the doctor for a chronic condition, and 17 per cent for a "check-up" at their last visit.

About one in ten, 11 per cent, last saw the doctor because of an acute illness; but this reason, unlike the others given, was more important among those whose visit had taken place longer than a year ago. A small number couldn't re-

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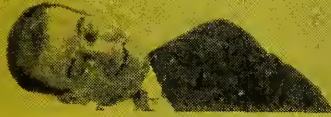
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Meclizine HCl (25 mg.) ... for antiveriginous, antinauseant effects.

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DOSAGE: usually one tablet at bedtime. Severe cases may require another dose on arising.

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2 to 6 years 3 cc.
adults and children over 6 1 tsp. (5 cc.)
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References: 1. Goldsmith, J. W.: Minnesota Med. 40:99 (Feb.) 1957. 2. Groskloss, H. H., et al.: Clin. Med. 2:885 (Sept.) 1955. 3. Weinberg, A., and Werner, W. E. F.: Am. Pract. & Digest Treat. 6:580 (April) 1955. 4. Crawley, C. R.: West. J. Surg. 8:463 (Aug.) 1956. 5. Tartikoff, G.: Clin. Med. 3:223 (March) 1955. 6. Dunn, R. D., and Fox, L. P.: Clinical exhibit. 7. Codling, J. W., and Lowden, R. J.: Northwest Med. 57:331 (March) 1958. 8. Dougan, H. T.: Personal communication. 9. Leonard, C. L.: Personal communication. 10. Steinberg, C. L.: Personal communication.



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member the reason for the visit, or the information was otherwise unavailable.

Use of Hospitals

The average annual admission rate to general hospitals for persons aged 65 and over in this survey was 114 per 1,000 population. (The National Health Survey reported that the admission rate to short-stay hospitals during 1957-58 was about 20 per cent higher for persons aged 65 and over than for the total population.) But some individuals were admitted to a general hospital more than once in the course of a year, and thus the number of persons accounting for these 114 annual admissions was only 104 in each 1,000 of the population. The average stay during a year was 15.4 days for each person hospitalized.

Men in this study had higher admission rates to general hospitals than women, 130 and 100 per 1,000, respectively. The number of persons accounting for these admissions were 116 males and 93 females per 1,000. However, the average time spent in a hospital during a year for those hospitalized was higher for women, 15.6, than men, 15.2.

Nursing Care and Special Arrangements

Among persons aged 65 and over in this survey, 7.4 in each 100 had to have personal care at home (including nursing care) during the four weeks preceding the survey. The proportion was higher for women, 9.1 per cent, than men, 5.5 per cent. Most received this care from one person only, but one in five listed two persons as providing it.

For four out of five of the aged who had this care (80 per cent, about 6 per cent of the total sample), it was provided by a relative; and for one out of seven, 14 per cent, by a friend. Relatives were somewhat more important in the total for males than females, while friends were listed proportionately more often by females. Others mentioned as providing personal care were public health nurses, hired registered nurses, and hired practical nurses.

The person who provided the most help (i. e., the first person listed by the respondent) was available for an average of slightly over two weeks during the last four. The second person listed as helping spent on the average just under two weeks.

Personal care (including nursing care) was provided far less frequently by a visiting nurse service than by nonprofessional sources. Only about 5 per cent of those who had received care, (less than one-half of one per cent of the total sample), had received help from a visiting nurse in the past four weeks. Yet about one in four of

the aged, 24 per cent, said that there was a visiting nurse service in their area. Less than half, 45 per cent, said there was no such service; and nearly one-third, 31 per cent, did not know whether such a service was available.

Aside from personal care (including nursing care), about one in five of the aged, 21 per cent, had had to make special arrangements during the last four weeks because of their health. More than half of them (56 per cent of those making special arrangements, 12 per cent of the total sample) had to have a special diet. Over one-third, 35 per cent, had to have "shots"; about one in four, 28 per cent, had to have someone do their shopping; and one in eight, 13 per cent, had to have someone to do housework or chores for them, or stay home from work to be with them.

The proportion having to make special arrangements was considerably higher for women, 24 per cent of the total sample, than men, 17 per cent. The numbers for women were larger for almost all categories of the special arrangements listed, but particularly for shopping. This function was mentioned by 32 per cent of the women who had to make a special arrangement, but only 21 per cent of the men (about 8 per cent of the total sample of women, 3 per cent of the men).

Use of Appliances

Almost all of the aged in this survey, 96 per cent, used appliances or special health helps (eyeglasses, dental aids, and others), and most used two or more. The mean average was 1.9 per person using appliances, 1.8 per person in the total population (whether or not using appliances). About one out of four of the aged used only one, but as many as one in seven used three or more appliances.

By far the most common were eyeglasses, reported by 90 per cent of the aged, and dental appliances such as false teeth, bridges, or partial plates, by 70 per cent. Less often used were canes or crutches, by about 8 per cent of the aged, and special shoes, trusses, and hearing aids, each by 4 to 5 per cent.

Women used appliances to a greater extent than men. Thus 97 per cent of the women were users compared to 94 per cent of the men; and women averaged 1.9 per person against 1.7 for men. A larger proportion of the women used two appliances, 64 per cent, against only 47 per cent for men. And finally, women's heavier use applied to each of the major appliances. Ninety-four per cent of the women used eyeglasses against 86 per cent of the men, and 78 per cent used dental aids compared with 60 per cent for men.



New hope for fetal salvage

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The results of administering Delalutin before the 12th week of gestation to 82 women with habitual abortion were reported recently by Reifenstein.¹ Every patient had experienced at least three consecutive abortions immediately preceding the treated pregnancy. More than 68% of these women were delivered successfully and uneventfully following Delalutin therapy.

Boschann,² in a study of pregnancies with threatened abortion, found that:

- 37% of 73 pregnancies were carried to term without progestational therapy
- 64% of 42 pregnancies were salvaged by progesterone
- 83% of 73 pregnancies were salvaged by Delalutin

Eichner,³ found that with Delalutin fetal salvage of infants below term weight (1000 to 2000 gm.) was significantly improved.

108 (76%) of 142 babies of this birth weight survived without progestational therapy.

16 (100%) of 16 babies of this birth weight survived with Delalutin therapy.

A comparison study was made of a group of repeated aborters treated with Delalutin, and a group with a similar history treated with bed rest and sedation.⁴ Pregnancy salvage with Delalutin was twice that of the control group. Delalutin was found to be "highly active," well-tolerated and long-acting.

Delalutin offers these advantages over other progestational agents:

- longer-acting and more sustained therapy
- more effective in producing and maintaining a completely matured secretory endometrium
- no androgenic effect
- more concentrated solution requires injection of less vehicle
- unusually well-tolerated, even in large doses
- requires fewer injections
- low viscosity makes administration easier

DELALUTIN is also potent and safe therapy for: threatened abortion; postpartum after-pains; amenorrhea, primary and secondary; dysfunctional uterine bleeding not associated with genital malignancy; infertility with inadequate corpus luteum function; production of secretory endometrium and desquamation during estrogen therapy; premenstrual tension; dysmenorrhea; cyclomastopathy, mastodynia, adenositis and chronic cystic mastitis.

Administration and Dosage: Because of its low viscosity, Delalutin may be administered with a small gauge needle (deep intragluteal injection). Complete information on administration and dosage is supplied in the package insert.

Supply: Delalutin is available in vials of 2 and 10 cc., each cc. containing 125 mg. of hydroxyprogesterone caproate in sesame oil, and benzyl benzoate.

References: 1. Reifenstein, E. C., Jr.: *Annals N. Y. Acad. Sci.* 71:762 (July 30) 1958. 2. Boschann, H-W.: *ibid.*, p. 727. 3. Eichner, E.: *ibid.*, p. 787. 4. Hodgkinson, C. P.; Igna, E. J., and Bukeavich, A. P.: *Am. J. Obst. and Gyn.* 76:279, 1958.

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Durham-Humphrey Act . . .

Food and Drug Administration Officer Cites Value of Proper Control of Pharmaceuticals; Liberalization of Law Could Endanger Public Health

LIBERALIZATION of sales of drugs to the public for use in self-medication would be dangerous and unwise, an officer of the Food and Drug Administration wrote in a recent issue of *The Bulletin of the Cleveland Academy of Medicine*.

Discussing the Durham-Humphrey Amendment to the Federal Food, Drug and Cosmetic Act, N. E. Cook, of the FDA Bureau of Enforcement, discusses in detail the amendment and its purposes. The article follows:

Durham-Humphrey Act

The Durham-Humphrey Amendment to the Federal Food, Drug, and Cosmetic Act, which went into effect in 1952, defines certain drugs which may be sold only on the prescription of a practitioner licensed by law to prescribe or administer them, and it further provides that prescriptions for such drugs may not be refilled except as authorized by the physician. When the measure was being considered by Congress, Dr. Walter P. Martin, testifying in behalf of the American Medical Association, gave the Association's endorsement to the majority of the objectives sought by the legislation, including those that were finally enacted into law.

Three Categories

The three categories of prescription drugs defined in the amendment are: (1) Certain hypnotic or habit-forming drugs specifically named in the law, and their derivatives (principally the narcotics and barbiturates); (2) a drug which is not safe for lay use "because of its toxicity or other potentiality for harmful effect, or the method of its use, or the collateral measures necessary to its use," and (3) a "new drug" which has not been shown to be safe for indiscriminate lay use.

Prescription-restricted drugs must be labeled with the legend: "Caution: Federal law prohibits dispensing without prescription."

It is clear from the language of the law and its legislative history that this restriction to prescription sale applies not only to drugs that are inherently so toxic or habit-forming as logically to require such restriction, but it applies also to many

drugs which are relatively "safe" in themselves. Physicians generally agree that many of the modern drugs, even though "safe," or relatively so, insofar as inherent toxicity is concerned, ought to be restricted to prescription sale because of the conditions for which they are intended to be used and the diagnostic techniques and collateral therapeutic measures necessary to their use. Indeed many articles currently appearing in medical journals decry the excessive use of such drugs by physicians in minor illnesses, or in conditions where they are not clearly indicated. The situation would be immeasurably worse if there were no restriction on their sales and they were promoted to the public for use in self-medication.

Medicine Not Regulated

It should be here emphasized that this amendment is not designed to control or regulate the practice of medicine; rather it seeks to keep in the hands of the physician full control over the kind and quantity of the medication his patient receives. The physician who is engaged in the ordinary practice of medicine has no reason whatever to be concerned about possible violation of this law through misunderstanding or inadvertence.

It is true that a few licensed physicians have been prosecuted for alleged violation of this section of the law, just as an occasional physician is prosecuted for violating some other provision of the Federal Food, Drug, and Cosmetic Act. When a physician engages in any business that is subject to regulation under the Act he is bound by its provisions. For example, in one of our more notorious cases, we prosecuted two Indiana physicians for their activities in the promotion and distribution of a worthless remedy for diabetes.

Prefer Local Action

Actually we do not investigate any physician unless we have good reason to believe that he is engaged in the business of selling drugs wholly apart from the practice of medicine. The usual reasons for these investigations are reports of injury and/or complaints of local law enforcement officers that a physician's activities are a menace to the community. We prefer to see abuses in this field controlled under the Medical Practices

Acts of the States, if that is possible. Where State control has proved unsuccessful or where there is no effective State control, we will, if the facts warrant, make an investigation, recognizing that we must assume a heavy burden of proof in charging a physician with the illegal sale of prescription-restricted drugs. What we have to do is to show that no bona fide doctor-patient relationship existed and that consequently the physician's actions bore no reasonable relationship to the legitimate practice of medicine.

Case Described

Perhaps it would be well to describe a typical case that was brought against a physician. We had a complaint from the sheriff's office that a physician was supplying barbiturates and amphetamines to juveniles; that he was suspected of creating and catering to addiction or habituation to such drugs. We interviewed one man who had been arrested several times while under the influence of amphetamines and he confirmed that he bought them in large quantities from this doctor simply by asking for them, often buying 1000 or more tablets at a time if he had enough money. We interviewed a prominent local physician and were told that the man's reputation among his fellow physicians was very bad indeed and that his activities ought to be stopped.

Our investigators, dressed as and acting the part of truck drivers, had no difficulty in buying from this physician amphetamine tablets in thousand tablet quantities without physical examination or directions for use, or even inquiry as to the use to which the drugs were to be put. At the trial, we presented expert medical testimony to the effect that selling drugs in that manner did not constitute legitimate medical practice, and that drugs dispensed in that manner would constitute a danger not only to the person taking them but to the community as a whole.

The case was tried before a jury and the physician was convicted of selling the drugs without a bona fide "prescription." On appeal to the Circuit Court the decision was affirmed, the Court commenting as follows: "The . . . tablets were acquired by the 'purchasers' who were not 'patients' without either a written or oral prescription, no matter how broadly the word 'prescription' is to be construed."

This case was appealed to the Supreme Court where *certiorari* was denied, in effect confirming the conviction and sentence.

As previously noted, it is quite rare for us to bring a case against a physician under this section of the law, and such cases receive perhaps an in-

ordinate amount of publicity simply because they are unusual and therefore newsworthy.

Reckless Refilling

We earnestly wish that we could report that there is general and satisfactory compliance with this law by pharmacists, but unfortunately we cannot. While few pharmacists will sell dangerous or habit-forming drugs directly over the counter without a prescription, we still receive far too many complaints about reckless and repetitious refilling of prescriptions without authorization from the prescriber. It is a problem that is giving us a great deal of concern, and it is an area in which we believe you as physicians can perform a very real service in promoting compliance with the law by pharmacists.

We want to emphasize that in our experience the indiscriminate refilling of prescriptions for dangerous and habit-forming drugs is just as much a hazard to the public health as the sale of these drugs without prescription. Quite often when we investigate an injury due to a drug we find that at sometime or other the injured person had a prescription for that drug, and was continuing to have that prescription refilled without the knowledge or approval of the prescribing physician.

Perhaps it would be well to describe a refill case against a pharmacist from among those currently being processed in this office. We made an in-

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vestigation of a store after we had two separate complaints that it was supplying barbiturates to addicts, either without prescription or as unauthorized refills of prescriptions.

From a cooperating physician we obtained two prescriptions, one for 18 Nembutal capsules, one and one-half grain, with directions "One at bed-time if needed for sleep," and a prescription for 30 Dexedrine tablets, 5 milligram, with directions "One on arising and one at noon before meal." Our inspector filed these prescriptions in the suspected store, and thereafter when he could conveniently visit the store (usually at about weekly intervals) he requested refills.

Physician Not Asked

In this fashion the Nembutal prescription was refilled 10 times without any attempt on the part of the pharmacist to obtain authorization from the prescriber, and indeed without any suggestion by the pharmacist that the physician ought to be consulted. Twice the prescription was refilled for a quantity greater than it called for (once for 50 capsules) simply on request and without significant comment.

In a similar manner the Dexedrine prescription was filled nine times without authorization from the prescriber, and once, on request, the pharmacist supplied 50 tablets instead of the 30 called for by the prescription.

This pharmacist, in accordance with the procedure established in the law, was given an opportunity at a hearing to show cause why he should not be prosecuted for these illegal sales. The pharmacist did not deny the charges and readily admitted that he knew what he did was illegal. The only excuse he offered for his actions was that he had found from experience that doctors are likely to "get mad" when called about a refill; and he indicated that he had more or less drifted into a policy of refilling on request without consulting the prescribing physician if he "knew the customer."

More than one hundred pharmacists are cited every year for this kind of violation, and it is quite common for them to tell us that physicians are annoyed and sometimes even angry when called for authorization to refill a prescription, despite the fact that the pharmacist is required by the law to seek that authorization before refilling a prescription for a prescription-restricted drug. Sometimes they also tell us that there has grown up a kind of "general understanding" between pharmacists and physicians in a particular area that prescriptions other than those for narcotics, may be refilled at the discretion of the pharmacist. Unfortunately, even if such a "general understand-



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ing" exists, that does not relieve the pharmacist of his legal responsibility.

Law Is Clear

The law is clear and direct in requiring that a prescription or a refill authorization to be valid must be from "a practitioner licensed by law"; and there is no way that we by administrative action could change that requirement even if we wished to do so. In any event, our experience has clearly demonstrated that some pharmacists have not used care and professional judgment in refilling prescriptions, and that the legal provision which reserves to the physician the prerogative of determining whether and to what extent a prescription should be refilled is needed for the protection of the public health.

A great deal of annoyance and misunderstanding can be avoided and compliance with the law facilitated if the physician at the time of writing or telephoning the original prescription includes instructions about refilling. The physician can, of course, authorize as many refills, or refilling for as long a time as his professional judgment indicates to be necessary or desirable before he sees his patient again. Prescription blanks that make it convenient for the physician to give such instructions are now widely used.

We would like to add a brief comment about the use of refill instructions such as "ad lib," "as requested," or "p.r.n." We have investigated cases where prescriptions for hypnotics, such as the barbiturates, or central nervous system stimulants, such as the amphetamines, were being refilled on an almost daily basis many years after they were written. Obviously, the drugs in these cases were not being supplied in accordance with the will and purpose of the physician who wrote the original prescription. Nevertheless, if the refill instruction on the original prescription was of the indefinite or continuing type referred to above, correction of abuses is complicated and difficult.

Study Gives Data on Doctors and How Public Receives Them

The average family doctor today is a well-established physician in his forties who treats about 26 patients a day and spends more than eight hours a day on home and office calls, according to Health Information Foundation, based on a survey made in cooperation with the University of Chicago's National Opinion Research Center.

The study was intended primarily to find out what the American public thinks and does about health and health facilities.

These major survey findings were brought out in the Foundation report:

Most of the physicians in the sample were relatively young men. The largest group (over one-third) were in their forties, and doctors under 40 constituted an additional quarter of the total.

The average doctor interviewed spent about six hours a day on office calls and another two hours on house calls. Only one doctor in every fourteen made no house calls, and four out of five physicians were generally available for night and Sunday emergency calls.

About seven out of every eight family doctors were affiliated with one or more hospitals, and more than half of all physicians performed some free work in hospitals.

Four out of five persons interviewed said they had a family physician to whom they turned regularly when they were sick. Most patients, furthermore, "reported a very good opinion of the abilities of their family physicians, reflecting a confidence that is certainly related to success in patient care."

The American Rhinologic Society will hold its fifth annual meeting in the Belmont Hotel, Chicago, October 10. This will be preceded by a surgical seminar in the Illinois Masonic Hospital, Chicago, October 7-9.

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GHI and U. S. Have Plan For Prepaid Mental Care

Group Health Insurance, Inc., of New York City and the Federal government are collaborating in an experimental project whose possibilities are unlimited. National Institute of Mental Health has granted GHI \$300,000 to help finance a 2-year program designed to combat mental illness with preventive medicine through medium of prepayment. In other words, government will subsidize private, voluntary health insurance so that it may broaden benefits without increasing charges.

Over a 2-year trial period, a cross-section of 30,000 GHI members in Greater New York will be entitled to psychiatric services in office and hospital at a fraction of the actual cost. Major part of the expense will be borne by the \$600,000 special pool contributed in equal parts by GHI and National Institute of Mental Health.

Very few prepaid health insurance plans in force today, nonprofit or commercial, cover mental and nervous ailments or their prevention. Purpose of this new project is to determine feasibility of broadening benefits and ascertaining what premium costs would have to be.

The NIMH-GHI plan is reminiscent of a bill that was introduced in Congress a decade ago. Among sponsors were Richard M. Nixon, then a Housemember; Rep. Christian Herter, now Acting Secretary of State, and Rep. Jacob J. Javits, presently a Senator from New York. All of its supporters were liberal Republicans who sought to divert attention from *compulsory* insurance scheme then being advanced by liberal Democrats. Measure they championed authorized large subsidies to voluntary prepayment plans that would step up benefits and/or reduce premium charges.

The Nixon-Javits-Flanders-Ives-Herter, etc., bill was never approved, partly because the Murray-Dingell crisis soon subsided and partly because the idea was not encouraged by Eisenhower Administration. Interesting sidelight: The man who framed the bill was Winslow Carlton, who later was to become one of the founders of Group Health Insurance, Inc., and chairman of its board of directors.

The 30,000 members to whom mental health coverage will be offered at no additional premium charge are now being selected by statisticians. By age, sex and vocation, they will be chosen in numbers proportionate to urban distribution.—*Washington Report on the Medical Sciences*.

There are 8,455 active and retired physicians in the U. S. who are 80 years of age or older, according to AMA records.

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In Memoriam . . .

Horace Q. Alexander, M. D., Sarasota, Florida; Pulte Medical College, Cincinnati, 1897; aged 88; died May 11. Dr. Alexander practiced in Russells Point from 1923 until 1955 when he retired and moved to Florida. He formerly also practiced in Elida and Dayton. A son and his widow by a second marriage survive.

William B. Carpenter, M. D., Sunbury; Starling Medical College, Columbus, 1903; aged 88; died May 23. Dr. Carpenter practiced a total of 56 years, most of that time in the eastern area of Delaware County. He was a member of the Masonic Lodge. Surviving are his widow, a daughter and three sons.

Carl Dacosta Hoy, M. D., Columbus; Northwestern University Medical School, 1907; aged 76; died May 5; former member of the Ohio State Medical Association. A practicing physician for many years in Columbus and a pioneer in the field of bone surgery, Dr. Hoy was for 16 years prior to his retirement in 1945 chief of staff and head of the surgery department in White Cross Hospital. He was a veteran of World War I, having served in the Medical Corps. Surviving are his widow and a daughter; also his aged mother, a resident of Wellston.

Martin Francis Vereker, M. D., Hamilton; Medical College of Ohio, Cincinnati; 1902; aged 83; died May 4; member of the Ohio State Medical Association and the American Medical Association. Dr. Vereker practiced medicine for 57 years in Hamilton, where he formerly served on the city council and was at one time city health commissioner. Affiliations included memberships in the Fraternal Order of Eagles and the Catholic Church. Surviving are his widow and two sons.

Fort Steuben Academy

"Auscultation in Congenital Heart Disease" was the topic of discussion at the May 12 dinner meeting of the Fort Steuben Academy of Medicine in Steubenville. Speakers were Dr. Ernest Craige, associate professor of cardiology, North Carolina Memorial Hospital, Chapel Hill, N. C., and Dr. M. H. Rosenblum, Department of Internal Medicine, Ohio Valley Hospital.

Two physicians participated in the "Professional Night" program of the Community Club of South Charleston in May. Dr. Edward C. Nehls, spoke on the topic, "Why Fear Your Doctor?" and Dr. Cecil D. McIntire, discussed the subject, "Preventive Medicines."

One of Every Seven Medical Bills \$500 or Greater, Report Says

One out of every seven medical bills on which health insurance pays benefits amounts to \$500 or more, the Health Insurance Institute reports. More than half of the bills fall between \$100 and \$499. The remaining one-third are less than \$100.

The report, based on a nationwide consumer survey of health insurance conducted for the Institute by National Analysts of Philadelphia, showed 32 per cent of claims were under \$100, some 54 per cent were in the \$100-\$499 category, and 14 per cent were \$500 or more.

When asked how much of their medical bill was paid by health insurance, some 53 per cent of the families questioned said they received payment for most or all of their medical expenses on their most recent claim. Another 20 per cent said they were reimbursed for three-quarters of their expenses, and 15 per cent said they received payment for half the cost.

The vast majority of families expressed satisfaction with the amount they were paid on their claim. Some 72 per cent of families said they received the amount they expected. Another 12 per cent said they were paid more than they anticipated, and an equal proportion said they received less than expected.

Among families whose medical bill was \$500 or more, the Institute survey found, some 65 per cent said they received what they expected and 15 per cent said they received more than expected.

The 12 per cent of the total number of families who received less than they thought they would were asked to what they attributed the misunderstanding. Some 49 per cent explained that they had not understood the provisions of their insurance contract. Of the remainder, 28 per cent said that the medical bill exceeded the policy limit by a larger amount than expected; 9 per cent did not realize that their case was not covered under the terms of the policy; and 8 per cent said they differed with the insuring organization as to the classification of their claim.

Cincinnati Women Physicians Hold Annual Election

The annual election of the American Medical Women's Association, Branch 11 of the Cincinnati area, was held recently with the following Cincinnati physicians elected to office: President, Dr. Ruth C. Ferris; vice-president, Dr. Marie Miller; treasurer (re-elected), Dr. Eileen O'Ferrell; secretary (re-elected), Dr. Mary M. Martin, 3035 Clifton Avenue.

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safely and
effectively

The hypertensive under treatment is frequently burdened with side effects of therapy including states of depression, fatigue, and lethargy. He finds little joy left in his life and laughter is almost a forgotten experience.

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in mild hypertension

RAUTENSIN provides smoother antihypertensive action with no sudden rebounds or abrupt declines, and can be given over long periods of time without impairing mental alertness, producing excessive lethargy or drowsiness. When tachycardia is present, RAUTENSIN slows heart rate 10 to 15 per cent. RAUTENSIN is less likely to cause mental depression.¹ The apprehensive hypertensive is calmed, yet side actions are "... either completely absent or so mild as to be inconsequential."²

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each tablet contains 2 mg. of the purified alseroxylon complex of Rauwolfia serpentina

Dosage: For the first 20 to 30 days, 2 tablets (4 mg.) once daily, at bedtime. Thereafter, a maintenance dose of 1 tablet (2 mg.) daily will suffice for most patients.

in moderate to severe hypertension

RAUVERA produces smooth and steady antihypertensive action which persists over the entire twenty-four hours without peaks and valleys... no "saw tooth" effect. Patients show a marked subjective as well as objective improvement with a significant drop in blood pressure, yet with a very low incidence of side effects.³ Abrupt rise in blood pressure does not occur even when therapy is interrupted.⁴ Tolerance does not develop on prolonged administration. Sensitization reactions or postural hypotension do not occur. Headaches, fatigue, insomnia and "heart consciousness" rapidly disappear, leaving the patient feeling well and asymptomatic.

RAUVERA[®]

each tablet contains 1 mg. of purified alseroxylon complex of Rauwolfia serpentina and 3 mg. alkavervir (Veratrum viride fraction)

Dosage: One tablet 3 or 4 times daily, ideally after meals, at intervals of not less than 4 hours.

1. Moyer, J. H.; Dennis, E., and Ford, R.: Arch. Int. Med. 96:530, 1955.
2. Terman, L. A.: Illinois M. J. 3:67, 1957.
3. La Barbera, J. F.: M. Rec. & Ann. 50:242, 1956.
4. Bendig, A.: New York J. Med. 66:2523, 1956.

Activities of County Societies . . .

First District

(COUNCILOR: CHARLES W. HOYT, M. D.,
CINCINNATI)

HAMILTON

Dr. Robert E. Howard has been chosen president-elect of the Academy of Medicine of Cincinnati. He will assume the post in September, 1960.

Dr. Clyde S. Roof, named president-elect a year ago, will begin his term next September 15.

Other new officers are: Dr. Edward Woliver, secretary; Dr. Carl W. Koehler, treasurer; Dr. Daniel V. Jones, trustee, Dr. Joseph E. Ghory, councilman-at-large; Drs. Harry K. Hines, Neal N. Earley and David L. Graller, delegates to the Ohio State Medical Association, and Drs. Sanford R. Courter and H. Willis Ratledge, alternate delegates.—*Cincinnati Post and Times Star*.

Second District

(COUNCILOR: RAY M. TURNER, M. D., SPRINGFIELD)

DARKE

The Darke County Medical Society held a dinner meeting on May 19 at the Treaty City White Shrine Temple in Greenville. The feature of the program was a film presentation on migraine.

GREENE

At a meeting of the Greene County Medical Society on May 14 at Greene Memorial Hospital, Dr. Colin R. MacPherson, assistant professor of medicine at Ohio State University College of Medicine, spoke on the control of staphylococcus infections in hospitals.

Dr. Paul Espey reported on the meeting of the Ohio State Medical Association in April and Dr. Eugene Schmidt gave a report on a disaster plan being developed for emergency situations.

The meeting was held in the doctor's room of the hospital.—*Xenia Gazette*.

Fourth District

(COUNCILOR: W. W. GREEN, M. D., TOLEDO)

DEFIANCE

At the June 6 joint meeting of the Defiance County Medical Society and staff of city hospital, representatives from Blue Cross discussed hospitalization problems with the medical staff. Also at the same meeting the group accepted Dr. James Cameron's motion regarding cost of treatment of outpatients—which will be determined by the attending physician.—J. Movchan, M. D., Correspondent.

PORTAGE

The May meeting of the Portage County Medical Society was held at Cherry's Steak House, Ravenna, with Dr. William Baird, of Akron, as guest speaker. He presented an interesting discussion of medical training and practice in England, as experienced during his recent six months in postgraduate neurosurgical training there. The Society has been actively promoting newspaper articles and editorials, urging polio immunizations.—Don P. VanDyke, M. D., Secretary.

Fifth District

(COUNCILOR GEORGE W. PETZNICK, M. D.,
CLEVELAND)

CUYAHOGA

Dr. Harry A. Haller was chosen president-elect of the Academy of Medicine of Cleveland. He will take office as president at the annual meeting in May of 1960.

Dr. Eugene A. Ferreri was installed as president for the current year, succeeding Dr. Chester R. Jablonoski. Dr. P. J. Robeck was elected vice-president and for the fourth time Dr. B. B. Sankey was re-elected secretary-treasurer.

The following new members were named to the 24-member Board of Directors: Drs. Joseph C. Avellone, Henry A. Crawford, Harry A. Haller, Howard Hopwood, Jr., Myron I. Pardee, John R. Reed, Martin B. Taliak and Julius Wolkin.

Guest speaker for the May 15 annual meeting was John Strohm, nationally syndicated newspaperman and the first American correspondent to visit Red China, whose subject was "Behind Red China's Bamboo Curtain." Members of the Woman's Auxiliary presented a skit entitled "Diet Is a Girl's Best Friend."

LAKE

The Lake County Medical Society held its bi-monthly meeting on May 13 in the Lutz' Hotel, Painesville. Speaker for the occasion was Dr. William J. Flynn, director of head and neck surgery in Youngstown Hospitals, whose subject was, "The Significance of a Lump in the Neck."

Members of the Lake County Medical Society also held a tri-county meeting with Ashtabula and Geauga Medical Societies on May 14 at the Madison Country Club. A team from the Cleveland Clinic conducted the program.

Sixth District

(COUNCILOR: ROBERT E. TSCHANTZ, M. D., CANTON)

MAHONING

Dr. A. H. Hendricks of 83 Homestead Drive, a general practitioner for 50 years, was awarded a

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special 50-year pin by the Ohio State Medical Association Tuesday night (May 19) at a meeting of the Mahoning County Medical Society at the Elks Club (Youngstown).

Dr. Hendricks, who has resided in Youngstown a year, was formerly director of communicable diseases for the Akron Department of Health. He received his medical degree in 1908 from Indiana University School of Medicine and interned at Detroit Receiving Hospital. He had been a practitioner in Indianapolis and Cleveland before moving to Akron, where he lived 13 years.

The pin was presented by Dr. M. W. Neidus, president of the Mahoning County Medical Society on behalf of the state group.

About 80 persons attended the dinner and heard a panel discuss problems common to both doctors and clergymen. Three clergymen representing the Protestant, Catholic and Jewish faiths participated. Dr. R. L. Tornello, program chairman, was moderator.

They included the Rev. Paul W. Gauss, D. D., executive secretary of the Youngstown Council of Churches; the Rev. John P. Gallagher, pastor of Holy Family Church, Poland, and Dr. Sidney M. Berkowitz, rabbi of Rodef Sholom Temple.

The clergymen discussed the need for autopsies; whether persons suffering from malignant diseases and without long to live should be informed of their plight; whether doctors and clergymen share the responsibility for the increase in faith healers, and whether doctors are morally obligated to keep patients alive even long after hope for survival has faded.

STARK

Dr. Jeannette C. Miller, Massillon, was honored at a recent award luncheon in the Massillon City Hospital for her more than half century of faithful service in the medical profession. Dr. K. M. Hoge, Jr., presented her with the 50-Year Pin and Certificate of the Ohio State Medical Association.

SUMMIT

Dr. Frederick A. Collier, emeritus professor of surgery at the University of Michigan, was guest speaker for the June 2 meeting of the Summit County Medical Society. His subject was "Thrombosis and Embolism, Diagnosis and Treatment." Dinner at the Akron City Club was followed by the program in the Akron City Hospital Auditorium. Dr. Collier also conducted a case presentation and discussion session in Akron City Hospital during the afternoon.

Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

BELMONT

The Belmont County Medical Society with the Auxiliary met for dinner and a program at the

Belmont Hills Country Club on May 21. The speaker was Dr. Joseph H. Nodurft who discussed anesthesiology.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

SCIOTO

Dr. William Stanley Smith, professor of orthopedic surgery, Ohio State University College of Medicine, Columbus, was guest speaker at the June 8 meeting of the Scioto County Medical Society. His subject was "Pitfalls of Treatment of Common Fractures." The program was held in the Nurses Recreation Hall of the Portsmouth General Hospital.

Dr. Atis Freimanis, assistant professor of radiology at University Hospital, Columbus, spoke on the subject, "Gall Bladder Radiology," at the May 11 meeting of the Scioto County Medical Society. The program arranged by Dr. Samuel L. Meltzer, was in the Nurses' Recreation Hall of the Portsmouth General Hospital, with a buffet supper following the meeting.

Tenth District

(COUNCILOR: ROBERT M. INGLIS, M. D., COLUMBUS)

MADISON

Mrs. Christine Evans was guest speaker at the May meeting of the Madison County Medical Society held Wednesday night, the 13th, at Coover House. Mrs. Evans related pertinent and interesting episodes from her experience as administrator of Fayette County Memorial Hospital for the past ten years. Originally designed to accommodate a daily load of thirty-five patients but since expanded to a seventy bed facility, the Fayette County institution is currently operating at well over one hundred per cent capacity. Stressed repeatedly was the absolute need for staff organization and cooperation in the successful operation of a community hospital.

Dr. Sol Maggied, Society Delegate, reported on the activity of the House of Delegates of the Ohio State Medical Association and other features of the State Convention held at the Veterans Memorial in Columbus April 21-24.

In addition to Mrs. Evans, the following were in attendance: Dr. and Mrs. J. Ayulo, Dr. and Mrs. W. T. Bacon, Dr. and Mrs. E. S. Crouch, Dr. and Mrs. W. J. Hurt, Dr. and Mrs. J. A. Knapp, Dr. Sol Maggied, Dr. and Mrs. Martin Markus, Dr. J. M. Morse, Dr. and Mrs. R. S. Postle, and Dr. and Mrs. Paul Wolber.

Provided no call for a special meeting is issued by Society president Dr. W. T. Bacon during the summer months, no sessions will be scheduled

prior to the September meeting.—Paul G. H. Wolber, M. D., Secretary.

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

LORAIN

Lorain County Medical Society held its 12th Annual Medical Symposium May 13 at the Oberlin Inn with 95 members and guests present. A team of five physicians from the Faculty of Medicine, Toronto University, Canada, provided an outstanding scientific program as follows:

RH Factor in Pregnancy, Dr. D. J. Van Wyck.

Newer Concepts in the Management of Cerebral Strokes, Dr. H. J. M. Barnett.

Current Therapy in Diabetes, Dr. T. A. Crowther.

Management of the Severely Injured Patient, Dr. J. R. F. Mills.

Following a Social Hour, Dinner and brief business meeting Dr. M. W. Johnston presented "Current Applications on the Use of Radio-Active Isotopes in Diagnosis and Treatment."

The applications of Drs. R. P. Hardwig and Boyd Parks received first readings. Dr. Denis A. Radefeld presided throughout. The program was arranged by Dr. Charles Chesner of Lorain.

Dr. H. T. Pease, councilor of the 11th district, was present and spoke briefly. Dr. Sauder of Ashland also attended, and 16 residents and interns of hospitals in the county were guests of the Society.

The successful establishment of Blue Cross-Medical Mutual Group Insurance Plans was announced for both the physicians and the office assistants.

While there will be no regular meetings during the summer months the Society is actively planning for a second High School Sports Injury Conference in August, and also a large health exhibit at the Lorain County Fair.—Lawrence C. Meredith, M. D., Secretary-Treasurer.

Cleveland Health Museum

A 30 per cent increase in attendance in 1958 was reported to the Cleveland Health Museum's annual Board of Trustees meeting, by Bruno Gebhard, M.D., director. The banner year brought 86,598 visitors to the Health Museum, compared to 65,000 in 1957. Big attendance getters were the exhibit "Project: Man in Space" and the Cleveland Book Fair.

Officers elected at the meeting were Dr. Robert M. Stecher, president; Mr. A. A. Hutton, vice-president; Mr. Howard Whipple Green, secretary; Mr. Warner Seely, treasurer.

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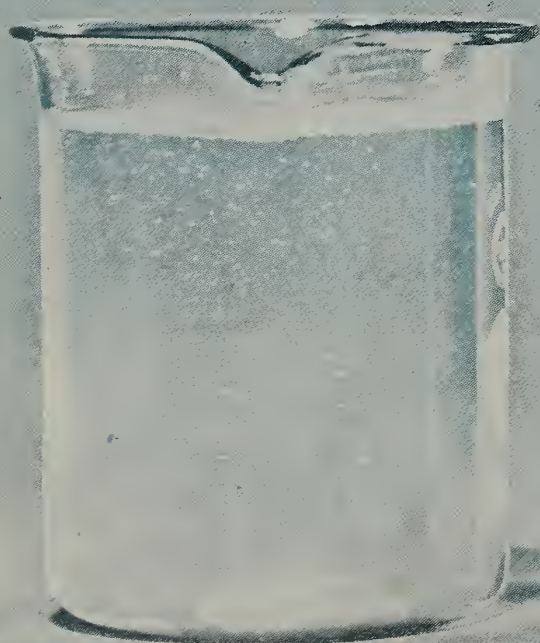


avoid the risk of insoluble, irritating aspirin particles

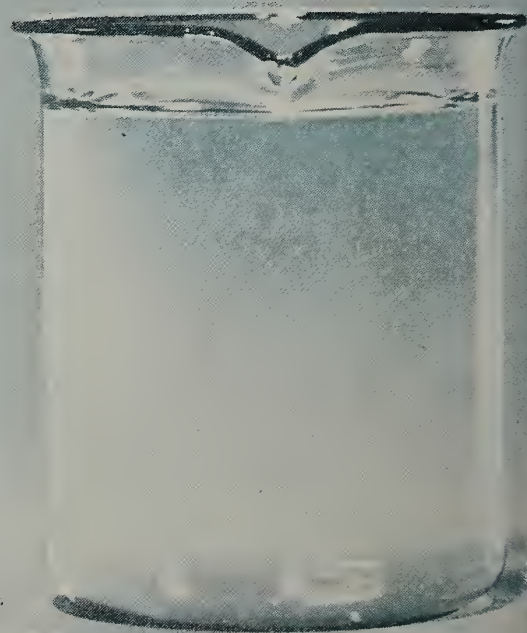
Chief among the drawbacks to aspirin usage is gastric intolerance. This ranges from mild upset and "heartburn" to severe hemorrhagic gastritis.¹⁻¹⁰ Studies performed in conjunction with gastrectomy^{4,5} and gastroscopy² have shown insoluble aspirin particles firmly adherent to

the gastric mucosa and imbedded between rugae. Reactions varying from mild hyperemia to erosive gastritis have been reported to occur in the areas immediately surrounding these adherent particles.^{2,4,5} This is reported to be particularly true in patients with peptic ulcer.⁴

CALURIN is the freely soluble, stable calcium aspirin complex. Its high solubility forestalls gastric irritation or damage



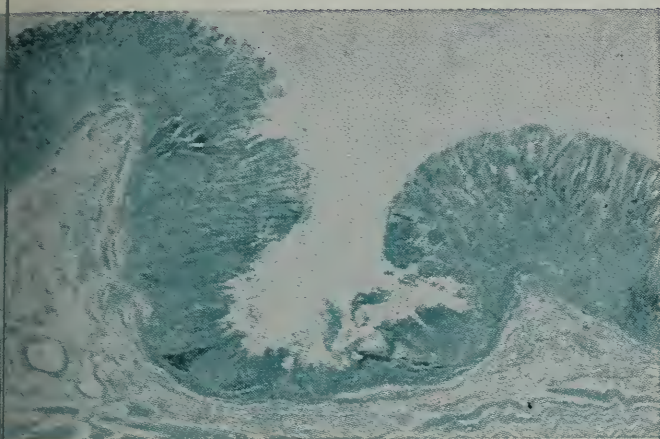
Regular aspirin crystals 24 hours after being mixed into water.



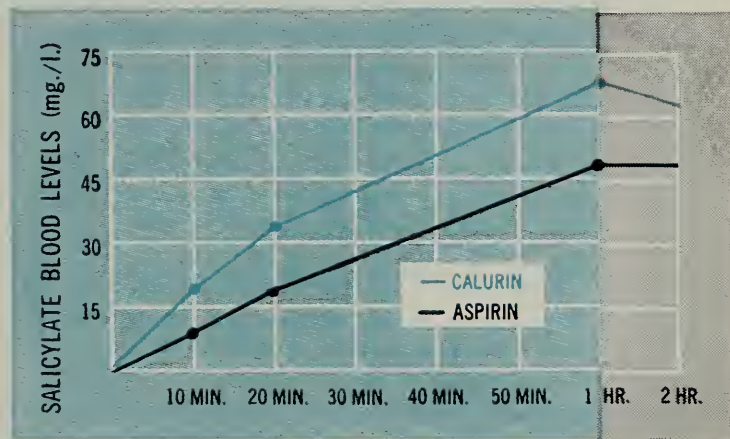
Calurin crystals in solution one minute after being mixed into water.

CALURIN*

STABLE SOLUBLE CALCIUM-ACETYSALICYLATE-CARBAMIDE



Particle-induced ulceration—section through lesion and in gastrectomy specimen. An aspirin particle was firmly imbedded in this undermined erosion. Such lesions may be associated with the relative insolubility of aspirin, which remains in particulate form after dispersion in gastric contents.



Calurin, being freely soluble, is promptly available for absorption into the systemic circulation. Salicylate blood levels in 12 subjects receiving both Calurin and plain aspirin were found to rise more than twice as high within ten minutes following Calurin. Also, these levels persisted higher for at least two hours.¹¹

CALURIN is the aspirin of choice, especially when high-dosage, long-term therapy is indicated:

- 1 High solubility forestalls gastric irritation or damage. This advantage is of special importance in arthritis and other conditions requiring high-dosage, long-term therapy.
- 2 Produces high salicylate blood levels rapidly for prompt analgesic, anti-pyretic, anti-arthritic effect.
- 3 Sodium-free — for safer long-term therapy.
- 4 Flavored: can be chewed or dissolved in the mouth without water if desired — an advantage for patients requiring aspirin administration during the night and for pediatric patients.

Dosage: Each tablet of Calurin is equivalent to 300 mg. (5 gr.) acetylsalicylic acid. For relief of pain and fever in adult patients, the usual dose of Calurin is 1 to 3 tablets every 4 hours, as needed; in arthritic states, 2 or 3 tablets 3 or 4 times

daily; in rheumatic fever, 3 to 5 tablets 4 or 5 times daily. For children over 6 years, the usual dose is 1 tablet every 4 hours; for children 3 to 6 years, ½ tablet every 4 hours, as required. Not recommended for children under 3.

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*TRADEMARK

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Soviet Medical-Health Program . . .

U. S. Mission Finds Great Strides Being Made by Russia In Expansion of Services, But also That Quality in the U. S. S. R. Is Not Up to Ours

AN "almost explosive extension" of disease prevention and medical care has taken place in the Soviet Union but the quality of service falls short of that found in the United States, according to a report released by the U. S. Public Health Service, containing the findings of a mission of five doctors who visited the Soviet Union.

Some Mass Problems Conquered

The report states that Soviet medical establishments are "antiquated or jerry-built" in contrast to those in the United States; pestilential diseases and the diseases of filth have been substantially brought under control in the Soviet Union; malaria as a significant health problem is on the way to eradication; venereal disease has been mastered but tuberculosis remains a plague.

The mission consisted of Dr. Thomas Parran, chairman, former Surgeon General of the U. S. Public Health Service (1936-1948), now president and trustee of the Avalon Foundation, New York, New York; Dr. Otis L. Anderson, Assistant Surgeon General for Personnel and Training, Public Health Service; Dr. Henry van Zile Hyde, Assistant to the Surgeon General for International Health, Public Health Service; Dr. Malcolm Merrill, California State Director of Public Health; and Dr. Leonid S. Snegireff, Associate Professor of Cancer Control, Harvard School of Public Health.

Other Findings

Other findings of the Mission included the following:

The health program of the Soviet Union is, like all programs, subject to the needs of the State and is therefore circumscribed by a series of allocations and goals.

The health program is an instrument of State policy because the Soviet Union recognizes the importance of having a healthy working class if it is to achieve its major goals.

Women represent the majority of practicing physicians in the Soviet Union.

Medicine is considered an important but not a primary contributor to the Soviet economy.

The average Soviet physician does not enjoy the same status as a Soviet engineer.

The number of physicians trained annually ex-

ceeds the number trained in the United States but the quality of basic training is at a much lower level.

Limitations on Practice

Clerical help and office equipment of the kind found in the United States medical facilities are regarded as "unheard-of-luxuries."

The Soviet Union's system of medical care does not provide for free choice of physician by the patient, nor does it usually allow the physician to select his place of practice.

Soviet medicine is, to a large extent, dependent upon clinical diagnosis with a minimum of laboratory support.

The Soviet pharmacopeia in practice is much more limited in quantity and quality than that in the United States as to range of available antibiotics and chemotherapeutic agents.

The Soviet Union is giving high priority to the extension of medical care and the improvement of health.

Health and medical services are provided without cost to all citizens of the Soviet Union.

Special attention is given to mothers prior to delivery of their children and during the postpartum period.

Facilities are widely provided for daytime care of pre-school children so that mothers can be released for work.

Health departments are taking an active part in city planning from the standpoint of sanitation and health facilities.

Foundation's Science and Educational Grants Include Several in Ohio

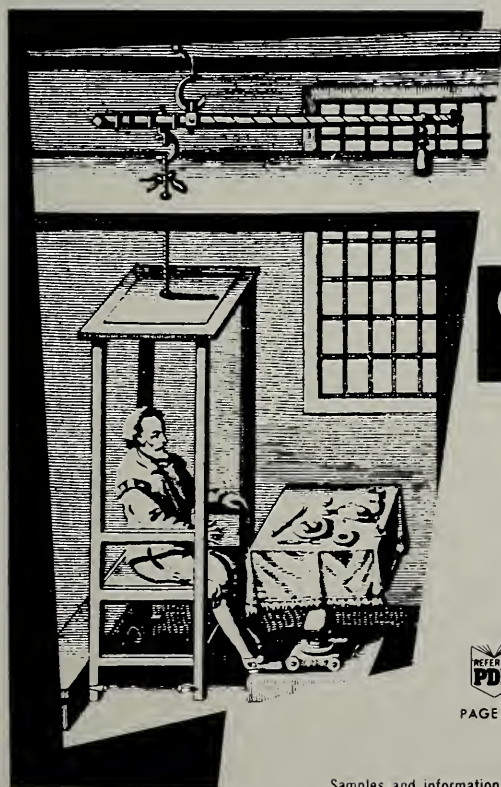
The Smith Kline & French Foundation gave grants amounting to \$20,900 to institutions in Ohio during 1957 and 1958. The grants were: Children's Hospital Research Foundation, Cincinnati, \$5,000; Columbus Psychiatric Institute, \$3,000; Ohio State University, \$2,500 in 1957 and \$6000 in 1958; University of Cincinnati College of Medicine, \$1,000; University of Cincinnati College of Pharmacy, \$1,500; Western Reserve University, \$1,500 in 1957 and \$400 in 1958.

The Foundation disbursed \$1,240,251 in grants to science, education and charity nationwide during the two-year period. This brought to \$2,698,127 the amount given since its inception in 1952.

Poison Information Centers in Ohio

These centers have agreed to cooperate in a program to extend their services to any physician requesting information from them. When a center is called the physician should have four basic facts in mind: (1) The full name or brand of the product ingested or inhaled; (2) An accurate estimation of the amount of the particular agent ingested; (3) The time of ingestion; (4) The age and weight of the patient.

Location	Facility	Telephone
Akron	Children's Hospital W. Bowery and W. Bechtel	BL 3-5531, Ext. 246
Cincinnati	The Academy of Medicine of Cincinnati 152 E. Fourth St.	PA 1-2345
Columbus	Children's Hospital 561 S. 17th St.	CL 8-9783
Cleveland	Cleveland Academy of Medicine 2121 Adelbert Road	CE 1-4455
Springfield	City Hospital E. High St. and Burnett Rd.	FA 3-5531, Ext. 226
Toledo	Toledo Health Department 635 N. Erie St.	CH 4-1961—(Day) GR 9-2244—(Night)



Sanctarius on his steelyard chair in the act of weighing himself for a metabolism experiment

in obesity

bring the ... MOOD UP
... WEIGHT DOWN
keep BLOOD PRESSURE LEVEL
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Each GRANUCAP® (Sustained release) capsule contains:

Dextro Amphetamine Sulfate	15 mg.	Vitamin C	30.0 mg.
Amobarbital	45 mg.	Ferrous Sulfate	20.0 mg.
Vitamin A	6,600 Units	Cobalt Sulfate	0.49 mg.
Vitamin D	400 Units	Copper Sulfate	2.8 mg.
Vitamin B-1	1.6 mg.	Sodium Molybdate	0.45 mg.
Vitamin B-2	2.5 mg.	Zinc Sulfate	3.9 mg.
Niacinamide	15.5 mg.	Potassium Iodide	0.13 mg.



PAGE 826

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Activities of Woman's Auxiliary . . .

CHAIRMAN PUBLICITY COMMITTEE—Mrs. W. J. Horger,
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(See Page 910 for roster of officers.)

COLUMBIANA

Nineteen members met for the annual Rose Luncheon at Timberlaine's, Salem on January 2.

Mrs. Wm. Banfield, president, presided. She introduced a new member, Mrs. R. J. Bonistolli.

Mrs. P. W. Conrad reported \$300 was given to AMEF.

Mrs. William Horger installed the officers for 1959-1960.

Mrs. Banfield presented the flower bedecked gavel to the new president, Mrs. A. P. Falkenstein.

Mrs. Virgil Hart presented the past-presidents' pin to Mrs. Banfield. Mrs. Falkenstein, the new president, appointed the following committees: Program chairman, Mrs. Virgil Hart; Legislature, Mrs. William Horger; Publicity, Mrs. R. J. McConnor; Civilian Defense, Mrs. V. E. McEl-downey; AMEF, Mrs. P. W. Conrad; Credits and Awards, Mrs. K. W. Turner; Mental Health, Mrs. M. M. Gottlieb; Visual Education, Mrs. J. A. Fraser; Safety, Mrs. Janis Lauva; Membership, Mrs. W. A. Kolozsi; *Today's Health*, Mrs. Costello, Chairman, Mrs. E. P. Schaefer, Salem; Mrs. C. W. DeWalt, Columbiana; Mrs. J. Jones, Lisbon; Mrs. C. Kissinger, E. Palestine; Mrs. P. H. Beaver, Leetonia; Finance, Mrs. Pritchard, Mrs. Virgil Hart, Mrs. Stevenson; Historian, Mrs. M. D. McCutcheon; Paramedical, Mrs. R. J. Starbucks; Community Service, Mrs. F. R. Crowgey.

The first meeting this fall will be held September 22.

HAMILTON

Maketewah Country Club was the scene of the May meeting of the Hamilton County Auxiliary. This final meeting of the year was an informal picnic featuring a hobby auction of articles donated by members. Most effective as the auctioneer was Mrs. Robert Woolford, complete with old-time costume. Chairmen of the day were Mrs. James Mills, hospitality, and Mrs. Walter Engel, program.

Hamilton County Auxiliary members elected to offices at the Ohio State convention in Columbus are: Agnes Van Horn, First District director; Gladys Warner, state treasurer; Ruth Woodward, parliamentarian.

MAHONING

Mrs. Earl H. Young, retiring president of the Woman's Auxiliary to the Mahoning County

Medical Society, handed the president's gavel to her successor, Mrs. Arthur E. Rappoport at the annual installation dinner May 6 at the Youngstown Country Club. About 50 members attended. Mrs. Edward Bauman of Warren, Sixth District president, was the installing officer.

Mrs. Cary Peabody, past-president, presented a gold bracelet charm to Mrs. Young as a token of appreciation. The charm designed by Mrs. Wm. H. Evans to be worn by presidents of county auxiliaries.

Mrs. Rappoport gave a report on the April meeting of the Woman's Auxiliary to the Ohio State Medical Association and announced that Mahoning County had won the state award for *Today's Health* for which Mrs. Lester Gregg was chairman. The announcement was made that the Mahoning County Auxiliary had contributed \$530.00 to the American Medical Education Foundation.

Featured on the after-dinner program was a take-off on "What's My Line?"

RICHLAND

The Woman's Auxiliary to the Richland County Medical Society met for luncheon at the Mansfield - Leland Hotel. Thirty - nine members were present.

The president, Mrs. Harry Wain, opened the meeting.

The treasurer's report showed a balance of \$420.36 as of May 1.

Mrs. Marvin Dees reported for the Ways and Means Committee. Through their projects this year they have turned in to the treasury a total of \$304.77.

The secretary announced the officers slate as follows: President, Mrs. Milton Oakes; president-elect, Mrs. Charles Butner; vice-president, Mrs. Carl Quick; treasurer, Mrs. P. O. Staker; recording secretary, Mrs. Charles Adair; and corresponding secretary, Mrs. L. C. Thompson.

Mrs. Wain called upon Mrs. Milton Oakes for a review of the business meetings at the State Convention held April 21-23 in Columbus, Ohio. Mrs. Charles Butner gave the social aspect of the same meeting.

Mrs. Harry Wain then covered the highlights of her presidential year, 1958-1959.

Mention was made by Mrs. C. H. Bell that Dr. Hattery was honored at Doctor's Day at the State Convention. Credit was also given to Mrs.

J. L. Stevens who worked with Dr. Hattery in forming the Richland County Medical Auxiliary.

ROSS

Ross County Medical Society Auxiliary's dinner, May 8, was at the home of the new president, Mrs. Wm Garrett.

Mrs. Robert Quinn, retiring president, conducted the meeting. She announced the auxiliary won a certificate of merit for the best executed program in their membership classification at the Ohio State Medical Association convention held recently. The group also received an award for sales of *Today's Health* magazine.

Mrs. Ernest Cutlip and Mrs. Richard Counts were appointed as the auditing committee.

Mrs. Quinn turned the meeting over to Mrs. Garrett, incoming president. Mrs. Stephen Fleischer reported on the Stork Club which is holding meetings at Chillicothe Hospital.

Mrs. John Franklin Sr. presided at the meeting of Hospital Guild 1, which followed. She appointed Mrs. M. D. Scholl, Mrs. Lewis W. Coppel, and Mrs. H. M. Crumbley as the nominating committee.

SCIOTO

Mrs. A. L. Berndt was installed as president of the Woman's Auxiliary to Scioto County Medical Society for the coming year at the annual May breakfast in the home of Mrs. H. M. Keil.

Installation of 1959-60 officers was conducted by Mrs. Wm. M. Singleton, a past-president of the organization. Mrs. Singleton presented each new officer and the retiring president, Mrs. Armin A. Melior, with a miniature Wedgwood ware medical urn.

Other new officers installed with Mrs. Berndt were Mrs. Miller F. Toombs, vice-president; Mrs. Garnett Neff, president-elect; Mrs. L. B. Hatch, secretary; Mrs. Donald M. Appleton, treasurer; Mrs. Robert N. Counts, historian; and Mrs. Melior and Mrs. Ralph W. Lewis, advisory board members.

Spring flowers decorated the Keil home and each member was presented with a china replica plate.

Corsages were presented by Mrs. Melior to Mrs. Samuel L. Meltzer, past state chairman of credits and awards, and to Mrs. Singleton, who has been elected Ninth District Auxiliary medical director.

Mrs. Melior thanked the corps of retiring officers for their support during the last year and displayed the "Award of Merit Certificate" won by the auxiliary in competition with the top nine auxiliaries of the state.

Cook County Graduate School of Medicine

INTENSIVE POSTGRADUATE COURSES

STARTING DATES — FALL, 1959

SURGERY—Surgical Technic, two weeks, Sept. 21, Oct. 19. Surgery of the Colon & Rectum, one week, Sept. 21. Thoracic Surgery, one week, Oct. 19. General Surgery, one week, Oct. 26. Board of Surgery Review Course, Part I, two weeks, Oct. 5. Fractures & Traumatic Surgery, two weeks, Oct. 12.

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, Sept. 28. Vaginal Approach to Pelvic Surgery, one week, Oct. 12. General & Surgical Obstetrics, two weeks, Sept. 14.

MEDICINE—Electrocardiography, two weeks basic course, Oct. 5. Gastroscopy & Gastroenterology, two weeks, Sept. 14. Internal Medicine, two weeks, Oct. 19.

UROLOGY—Two-Week Intensive Course, Oct. 26. Ten-Day Practical Course in Cystoscopy, by appointment.

RADIOLOGY—Clinical Uses of Radioisotopes, two weeks, Sept. 21.

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COMING MEETINGS

American Medical Association, Clinical Session, Dallas, Texas, November 3-6.

American Roentgen Ray Society, Cincinnati, September 21-25.

Chest Disease Symposium for General Practitioners, Saranac Lake, N. Y., July 6-10.

Northwestern Ohio Medical Association, Findlay Country Club, October 7, all-day session; registration 9:00 a.m.; first speaker, 9:45 a.m.

Ohio Chapter, American College of Surgeons, Annual Meeting, Statler Hotel, Cleveland, September 11, 12.

Ohio State University, Department of Ophthalmology, Course in Perimetry for Office Assistants, July 13-15; Course for Ophthalmology Secretaries, July 16-17.

Second District Postgraduate Program, Springfield, October 21.

First National Conference on Aging Held in Washington

More than 500 persons, who are interested in encouraging the expansion and improvement of health care facilities for the nation's aged population, gathered in Washington, D. C., June 12-13.

This First National Conference, which was held in the Sheraton-Park Hotel, was sponsored by the Joint Council to Improve the Health Care of the Aged made up of the American Dental Association, the American Hospital Association, the American Medical Association, and the American Nursing Home Association. The objectives of the Council are to correlate the efforts and resources of Member Organizations, as the principal purveyors of health care for the aged, and to establish liaison and a cooperative relationship with other organizations working with similar purposes. Dr. E. K. Yantes, Wilmington, represented the Ohio State Medical Association. He is chairman of the OSMA Committee on Care of the Aged.

Guest Speaker in Europe

Dr. J. J. Biber, Delaware, an honorary Fellow of the Hellenic Neuro-Ophthalmology-Otolaryngological Society in Greece, was invited to that country to speak during the Greco-Yugoslav Congress, the first such meeting between a Western country and one behind the Iron Curtain. His paper was on the subject of the present status of the cholesteatoma problem. He also visited his Alma Mater in Vienna.

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BUTLER—Clyde G. Chamberlin, President, 300 Rentschler Bldg., Hamilton; Mr. Charles G. Greig, Executive Secretary, 110 N. Third St., Hamilton. 4th Wednesday of alternate months.

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HIGHLAND—J. Martin Byers, President, 316 Midway, Greenfield; Kenneth Lyle Upp, Secretary, 136 S. Washington St., Greenfield. 1st Wednesday, monthly.

WARREN—Thomas E. Fox, President, 309 Reading Rd., Mason; D. Paul Ward, Secretary, Box 85, Pleasant Plain. 2nd Tuesday, monthly.

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HENRY—Edwin C. Winzeler, President, 812½ N. Perry St., Napoleon; Thomas F. Tabler, Secretary, 332 Railway Ave., Holgate. 1st Tuesday, monthly.

LUCAS—Maurice A. Schnitker, President, 1006 Secor Hotel, Toledo 3; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Blvd., Toledo 10. 3rd Tuesday, monthly.

OTTAWA—Cyrus R. Wood, President, 115 Madison St., Port Clinton; Robert W. Minick, Secretary, 124½ W. Water St., Oak Harbor. 2nd Thursday, monthly.

PAULDING—Edythe C. Pritchard, President, 509 N. Williams St., Paulding; D. E. Farling, Secretary, Main St., Payne. 3rd Wednesday, monthly.

PUTNAM—Walter E. Martin, President, 135 N. High St., Columbus Grove; Will W. Moody, Secretary, Vaughnsville. 1st Tuesday, monthly.

SANDUSKY—R. Allen Eyestone, President, Gibsonburg; Paul E. Burson, Secretary, Cor. Southwest & Center St., Bellevue. 3rd Wednesday, monthly.

WILLIAMS—Robert W. Dilworth, President, Main St., Montpelier; E. K. Bell, Secretary, P. O. Box 466, Bryan. Monthly meeting date varies.

WOOD—Stewart J. Smith, President, 106 N. Main St., Bowling Green; Richard L. Pearse, Secretary, 320 S. Main St., Bowling Green. 3rd Thursday, monthly.

FIFTH DISTRICT

ASHTABULA—Lewis H. Roth, President, 80 S. Broadway, Geneva; Albin F. Urankar, Secretary, Ashtabula Gen. Hospital, Ashtabula.

CUYAHOGA—Eugene A. Ferreri, President, 4070 Mayfield Road, Cleveland 21; Mr. Robert A. Lang, Executive Secretary, 2009 Adelbert Rd., Cleveland. 2nd Tuesday, monthly.

GEAUGA—George Dandalides, President, Chardon Medical Center, Chardon; Alton W. Behm, Secretary, 112 South St., Chardon. 2nd Friday, monthly.

LAKE—Richard W. McBurney, President, 124 S. St. Clair St., Painesville; Mrs. Owen A. McLaren, Executive Secretary, 1051 Cadle Ave., Mentor.

SIXTH DISTRICT

COLUMBIANA—William A. Kolozsi, President, 616 E. Seventh St., Salem; Leonard S. Pritchard, Secretary, 153 S. Main St., Columbiana. 2nd Tuesday, monthly.

MAHONING—M. W. Neidus, President, 318 Fifth Ave., Youngstown; Mr. Howard C. Rempes, Jr., Executive Secretary, 245 Bel-Park Bldg., 1005 Belmont Ave., Youngstown 4. 3rd Tuesday, monthly.

PORTAGE—Charles C. Whitsett, President, Robinson Memorial Hospital, Ravenna; Don P. VanDyke, Secretary, 607 E. Main St., Kent. 3rd Tuesday, monthly.

STARK—John R. Seesholtz, President, 1645 Cleveland Ave., N. W., Canton; Mr. E. M. Sprunger, Executive Secretary, 405 Fourth Street, Canton 2. 2nd Thursday, monthly, except May, June, July, August and September.

SUMMIT—Donald I. Minnig, President, 640 W. Market St., Akron; Mr. S. H. Mountcastle, Executive Secretary, 437 Second National Building, Akron. 1st Tuesday, monthly, September through June.

TRUMBULL—Paul E. Noonan, President, 1924 East Market St., Warren; Ralph H. Jamison, Secretary, 197 W. Market St., Warren. 3rd Wednesday, monthly.

SEVENTH DISTRICT

BELMONT—John A. Brown, President, Morristown; Bertha M. Joseph, Secretary, 100 S. Fourth St., Martins Ferry. 3rd Thursday, monthly.

CARROLL—Samuel L. Weir, President, 625 N. Market St., Minerva; Robert C. Lanzer, Secretary, 625 N. Market St., Minerva. 1st Thursday, monthly.

COSHOCOTON—Lewis E. Smith, Jr., President, 729 Main St., Coshocoton; Harold W. Lear, Secretary, 110 N. Seventh St., Coshocoton. 2nd Tuesday, monthly.

HARRISON—Elias Freeman, President, 264 S. Main St., Cadiz; Janis Trupovnick, Secretary, High St., Box 366, Hopedale.

JEFFERSON—Ernest L. Perri, President, 517 N. Fourth St., Steubenville; Jacob Mervis, Secretary, Sinclair Bldg., Steubenville. 2nd Tuesday, monthly.

MONROE—Byron Gillespie, Secretary, South Main Street, Woodsfield.

TUSCARAWAS—Chester A. Bennett, President, 533 Wooster Ave., Dover; George D. Woodward, Secretary, 201 Boulevard, Dover. 2nd Thursday, monthly.

EIGHTH DISTRICT

ATHENS—T. J. Najm, President, 422 W. Washington St., Nelsonville; Charles R. Hoskins, Secretary, Security Bank Bldg., Athens. 2nd Tuesday, monthly.

FAIRFIELD—Lloyd L. Kersell, President, 130 Union St., Lancaster; Arthur B. VanGundy, Secretary, 843 N. Columbus St., Lancaster. 2nd Tuesday, monthly.

GUERNSEY—Jesse B. Kellum, President, 840 Wheeling Ave., Cambridge; Thomas D. Swan, Secretary, 651 Wheeling Ave., Cambridge. 1st Thursday, monthly.

LICKING—Kurt J. Fleisch, President, 125 Hudson Ave., Newark; Jay Ross Wells, Secretary, 375 Granville St., Newark. Last Tuesday, monthly.

MORGAN—A. H. Whitacre, President, Chesterhill; C. E. Northrup, Secretary, Corner Main and Seventh St., McConnelsville. Called meetings.

MUSKINGUM—J. Herbert Bain, President, 67 W. Main St., New Concord; William A. Knapp, Secretary, 1025 Maple Ave., Zanesville. 1st Tuesday, monthly.

NOBLE—Charles F. Thompson, President, Caldwell; E. G. Ditch, Secretary, Caldwell. 1st Tuesday, monthly.

PERRY—Charles E. Bope, President, Somerset; O. D. Ball, Secretary, 203 N. Main St., New Lexington. Called meetings.

WASHINGTON—William R. Stewart, President, 407 Second St., Marietta; Donald S. Williams, Secretary, 222 Third St., Marietta. 2nd Wednesday, monthly.

NINTH DISTRICT

GALLIA—Thomas W. Morgan, President, Holzer Hospital, Gallipolis; Norman W. Pinschmidt, Secretary, Gallipolis Clinic, 52 State Street, Gallipolis. 3rd Thursday, monthly.

HOCKING—George B. Watson, President, Box 296, Adelphi; Howard M. Books, Secretary, Court House, Logan. Indefinite meeting dates.

JACKSON—Tom Washam, President, 35 Vaughn St., Jackson; Brinton J. Allison, Secretary, 267 Ralph St., Jackson. Called meetings.

LAWRENCE—Gerard C. Geswein, President, 1626 S. Sixth St., Ironton; George Newton Spears, Secretary, 422 South Sixth Street, Ironton. Monthly meetings on call.

MEIGS—Charles J. Mullen, President, 210½ E. Main St., Pomeroy; Selim J. Blazewicz, Secretary, 112½ E. Main St., Pomeroy. Last Wednesday, monthly.

PIKE—Paul H. Jones, President, Stockdale; George W. Cooper, Secretary, Piketon. 1st Tuesday, monthly.

SCIOTO—Ralph W. Lewis, President, 1025 Ninth St., Portsmouth; Carl H. Laestar, Secretary, 2829 Gallia St., Portsmouth. 2nd Monday, monthly.

VINTON—Richard E. Bullock, President, McArthur; H. D. Chamberlain, Secretary, W. Main St., McArthur.

TENTH DISTRICT

DELAWARE—Max W. Livingston, President, 28 North Vernon, Sunbury; Edward C. Jenkins, Secretary, c/o Mrs. Mabel Barrett, Jane M. Case Hospital, Delaware. 3rd Tuesday, monthly.

(Continued on Next Page)

COUNTY SOCIETIES' OFFICERS AND MEETING DATES (Continued)

FAYETTE—H. Wm. Payton, President, 36 S. Main St., Jeffersonville; Marvin H. Roszmann, Secretary, 107 N. North St., Washington C. H. 2nd Tuesday, monthly.

FRANKLIN—James L. Henry, President, 244 E. Park St., Grove City; Mr. William Webb, Executive Secretary, 79 East State Street, Columbus 15. Meetings in January, February, March, May, September, November and December.

KNOX—Henry T. Lapp, President, 4 Public Square, Mt. Vernon; Thomas L. Bogardus, Secretary, 50 Public Square, Mt. Vernon. Quarterly meetings.

MADISON—William T. Bacon, President, 40 E. First St., London; Paul G. H. Wolber, Secretary, 40 E. First St., London. 2nd Wednesday, monthly.

MORROW—Andrew Maciurak, President, 119 E. Main St., Cardington; William S. Deffinger, Secretary, Marengo. First Tuesday, monthly.

PICKAWAY—Henry H. Swope, President, 233 N. Court St., Circleville; Edward L. Montgomery, Secretary, 108 Seyfert Ave., Circleville. 1st Friday, monthly.

ROSS—Robert E. Quinn, President, 30 N. Walnut St., Chillicothe; G. Howard Wood, Secretary, 134 W. Main St., Chillicothe. 1st Thursday, monthly.

UNION—Paul R. Zaugg, President, 130 N. Maple St., Marysville; May B. Zaugg, Secretary, 130 N. Maple St., Marysville. 2nd Tuesday, monthly.

ELEVENTH DISTRICT

ASHLAND—R. Lee Schafer, President, 203 Maple Street, Ashland; Wayne C. Smith, Secretary, 140 Claremont Ave., Ashland. 1st Friday, monthly, except July, August.

ERIE—Richard F. Hoffman, President, Providence Hospital, Sandusky; Edward P. Gillette, Jr., Secretary, 410 Columbus Ave., Sandusky. Monthly meeting date varies.

HOLMES—Clyde Bahler, President, Walnut Creek; Luther W. High, Secretary, R. F. D. 4, Millersburg. 2nd Wednesday, monthly.

HURON—Walter A. Drury, President, Box 269, Willard; John V. Emery, Secretary, Box 269, Willard. 2nd Wednesday, March, June, September and December.

LORAIN—Denis A. Radefeld, President, 209 Sixth St., Lorain; Mrs. C. Ruth Zealley, Executive Secretary, 311 Elyria Block, Elyria. 2nd Tuesday, monthly.

MEDINA—Robert E. Smith, President, 403 East Liberty St., Medina; William G. Halley, Secretary, 115 Bank Street, Lodi. 3rd Thursday, monthly.

RICHLAND—Riley E. Frush, President, 36 S. Mulberry St., Mansfield; James O. Ludwig, Secretary, 336 Sturges Ave., Mansfield. 3rd Thursday, monthly.

WAYNE—Ralph I. Cottle, President, 230 N. Market St., Wooster; Robert E. Schulz, Secretary, Wooster Community Hospital, Wooster. 2nd Wednesday, monthly.

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3 **Adjust dosage of all medication:** the patient must be frequently observed and careful adjustment of all agents should be made to establish optimal maintenance dosage.

Supplied: 25 mg. and 50 mg. scored tablets HYDRODIURIL (Hydrochlorothiazide) bottles of 100 and 1,000. Additional literature for the physician is available on request.

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The Physician's Bookshelf

(Books received from publishers. *The Journal* is not obligated to list herein every book received. It will try to list those which appear to be of greatest interest.)

* * *

Surgical Pathology, by Lauren V. Ackerman, M. D., in collaboration with Harvey R. Butcher, Jr., M. D. (\$15.00, Second edition, *The C. V. Mosby Company, St. Louis 3, Missouri.*)

Immunity and Resistance to Infection in Early Infancy, Report of the Twenty-ninth Ross Pediatric Research Conference, by Ross Laboratories. (Apply, *Ross Laboratories, Columbus 16, Ohio.*)

Surgery in World War II; Neurosurgery: Volume I, by R. Glen Spurling, M. D., and Barnes Woodhall, M. D. (\$5.00, *Office of the Surgeon General, Department of the Army, Washington, D. C.*)

Now or Never; The Promise of the Middle Years, by Smiley Blanton, M. D., with Arthur Gordon. (\$4.95, *Prentice-Hall, Inc., New York 11, New York.*)

Aion: Researches into the Phenomenology of the Self; Collected Works of Volume 9, Part II, Bollingen Series XX. (\$4.50, *Pantheon Books, Inc., New York 14, N. Y.*)

Biosynthesis of Terpenes and Sterols: Ciba Foundation Symposium, by G. E. W. Wolstenholme and Maeve O'Connor. (\$8.75, *Little, Brown and Company, Boston, Mass.*)

Intra Vascular Catheterization, by Henry A. Zimmermann, M. D., and 23 contributors. (\$16.75, *Charles C. Thomas, Publisher, Springfield, Ill.*)

Gynecologic Endocrinology, by Gardner M. Riley, Ph. D., foreword by Norman F. Miller, M. D. (\$8.50, *Paul B. Hoeber, Inc., Publisher, New York 16, N. Y.*)

A Doctor Remembers, by Edward H. Richardson, M. D. (\$3.95, *Vantage Press, Inc., New York 1, N. Y.*)

Navy Surgeon, by Rear Admiral Lamont Pugh, MC, retired. (\$5.00, *Medical Department, J. B. Lippincott Company, Philadelphia 5, Penna.*)

Patient Care and Special Procedures in X-Ray Technology, by Carol Hocking Vennes, R. N., and John C. Watson, R. T. (\$5.75, *The C. V. Mosby Company, St. Louis 3, Missouri.*)

On the Mysterious Leap from the Mind to the Body, by Felix Deutsch, M. D., and fourteen contributors. (\$5.00, *International Universities Press, New York 11, New York.*)

Your Mind Can Make You Sick or Well, by Curt S. Wachtel, M. D. (\$4.95, *Prentice-Hall, Inc., Englewood Cliffs, New Jersey.*)

501 Questions and Answers in Anatomy, by Stanley D. Miroyiannis, Ph. D. (\$5.00, *Vantage Press, Inc., New York 1, N. Y.*)

The Degenerative Back and Its Differential Diagnosis, by P. R. M. J. Hanraets, M. D. (\$19.95, *Elsevier Press, Inc., Princeton, N. J.*)

Amino Acid and Protein Metabolism, by Ross Laboratories. (Apply, *Ross Laboratories, 625 Cleveland Ave., Columbus 16, Ohio.*)

Medicine and Anthropology, by Iago Galdston, M. D. (\$3.00, *International Universities Press, New York 11, New York.*)

Voyage from Lesbos, by Richard C. Robertello, M. D. (\$4.00, *The Citadel Press, New York 3, N. Y.*)

Insulin Treatment in Psychiatry, by Max Rinkel, M. D., and Harold E. Himwich, M. D. (\$5.00, *Philosophical Library, Inc., New York 16, New York.*)

Year Book of Endocrinology; 1958-1959 Series, by Gilbert S. Gordan, M. D., (\$7.50, *Year Book Publishers, Inc., Chicago 11, Illinois.*)

Clinical Orthopaedics No. 13, by Anthony F. DePalma, M. D., and contributors. (\$7.50, single copies and \$6.00, by subscription, *Medical Department, J. B. Lippincott Company, Philadelphia 5, Penna.*)

Experiment Perilous, by Renee C. Fox. (\$5.00, *The Free Press, Glencoe, Illinois.*)

Hypertensive Disease; Diagnosis and Treatment, by Sibley W. Hoobler, M. D. (\$7.50, *Paul B. Hoeber, Inc., New York 16, New York.*)

Elementary Statistics: With Applications in Medicine and the Biological Sciences, by Frederick E. Croxton, Ph. D. (\$1.95, *Dover Publications, Inc., New York 14, N. Y.*)

Anatomy and Physiology: Volume I, by Edwin B. Steen, Ph. D., and Ashley Montague, Ph. D. (\$2.50, *Barnes & Noble, New York 3, New York.*)

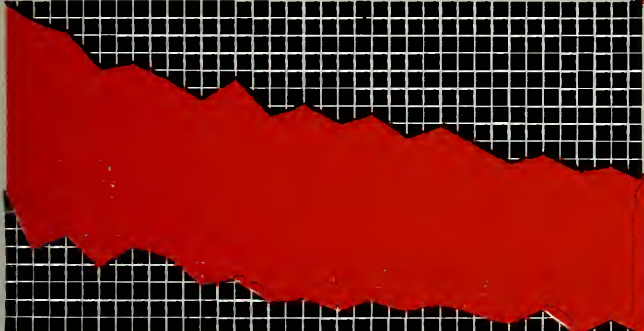
The New Psychiatry, by Nathan Masor, M. D. (3.75, *Philosophical Library, Inc., New York 16, New York.*)



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- With HYDROPRES, dietary salt may be liberalized.
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25 mg. HYDRODIURIL, 0.125 mg. reserpine.
One tablet one to four times a day.

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If the patient is receiving ganglion blocking drugs or hydralazine,
their dosage must be cut in half when HYDROPRES is added.



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Washington Roundup . . .

Ninety per cent of U. S. population in 65-plus age group who need and want it will be getting voluntary health insurance coverage by 1970, E. J. Faulkner, Health Insurance Council chairman, told national conference of Joint Council to Improve Health Care of Aged.

* * *

Defense Department is inviting 1959 medical school graduates likely to be called into service to apply for residency deferment. For year that started July 1, 1960, armed forces have 871 residencies, including 130 in psychiatry, 123 in surgery, 85 in pediatrics and 83 in internal medicine. Also, Air Force has 40 residencies for general practice and Navy has eight. Army has no general practice residencies.

* * *

Largest contract ever signed by National Cancer Institute's Cancer-Chemotherapy National Service Center was completed recently, involving award of \$1,437,172 to Sloan-Kettering Institute, New York City, for testing chemicals and other materials as anticarcinogenic agents.

* * *

Maintaining its continuous postwar increase, consumer cost index for medical care inched up 0.4 per cent in May, Bureau of Labor Statistics reports. Medical care index includes hospital rates, insurance premiums, some drugs and physicians' and dental fees.

* * *

Dr. George Fister, AMA trustee and chairman of its legislative group, told Senate Finance Committee's hearing on Keogh bill that "unless something is done to make self-employment as financially attractive as employee status, we believe that there is a real danger that many professional men will bypass the private practice of their profession."

* * *

Health, Education and Welfare Secretary Fleming has announced that \$810,000 is available in grants to states to help finance their preparations for the White House Conference on Aging to be held in Washington in January of 1961.

* * *

Striking at weight-reducing quacks and their products, Federal Food and Drug Administration has declared that "the only safe and effective way to reduce without medical supervision is the hard way—eat less, count your calories and stay with your diet consistently. Seriously overweight persons should consult a physician before attempting any weight reduction program."

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You and Your Public

As A Citizen, Physician Should Understand and Take Active Interest in Socio-Economic Affairs of His Community

ASK anybody and he'll tell you that he is a good citizen in his community. He obeys its laws (excepting an occasional sneak through a stop sign) and pays his taxes. He often doesn't know the local tax rate or who heads up the various departments of his local government.

This type is not a "good citizen." He is a "conforming citizen" in that he conforms to the minimum requirements for residing in his community.

To the physician, as to everybody, his town should be important to him. He practices medicine there, resides there, raises his family there. He wants it to be a good community.

The doctor should be a good citizen, not just a "conforming citizen." He should take an active interest in community affairs. He should know his local government, how it is operated, who operates it and how they were selected or elected. He should know his tax rate, his school system, his town's problems and what is being done to solve them.

As a member of a highly respected profession, the physician is in the position to be a leader in his community. He should know and understand the affairs of his community in order that he be a leader. When a community's men of ability divorce themselves from its affairs, there are those who readily step in and take over because of their own personal—and often times selfish—interests.

In short, a town can be just as good or just as bad as its citizens want to make it.

Quiz Yourself

If you want to find out if you are a real citizen of your community or merely reside there, check yourself with the following quiz, suggested by a magazine of national circulation:

1. Did you vote in the last local election? (20 points)
2. Do you know how the major local government offices, such as auditor, prosecutor, treasurer, police chief, fire chief, are filled? (10 points)
3. Can you name the members of your top local governing body? (10 points)
4. Can you give the approximate total of your town's annual budget? (5 points)

5. Do you know whether your town is in debt; if so, about how much and for what purpose? (5 points)

6. Do you know the approximate schoolteacher salaries in your community? (5 points)

7. How does your local tax rate compare with similar towns in Ohio: lower, higher, about the same? (5 points)

8. Do you have adequate fire protection? The best measure is how high your fire insurance rates are? Do you know how these rates compare with neighboring towns? (5 points)

9. Do you know if your community has a good program for inspecting food-handling establishments; supervised garbage disposal? (5 points)

10. Do you know if your community's population has increased or decreased over the past 10 years? Do you know which and how much? (5 points)

11. If the town population decreased, do you know why and have you ever discussed reasons and remedies? If it has increased, have you ever discussed problems created by growth? (5 points)

Do You Give Help?

12. Do you belong and take active part in some civic or service organization, such as a neighborhood civic, Chamber of Commerce, Parent-Teachers Association, Rotary, Kiwanis, Lions, Optimists, Boy Scout or Girl Scout movement, church board, etc.? (10 points for each but not more than a total of 20 points)

13. Have you taken a job in the last year in a civic campaign, like the Community Chest drive or some other community project? (5 points)

14. Do you contribute to a major organized charity? (5 points)

15. Do you keep up your home, have it looking neat, take pride in your neighborhood? (10 points)

Now add up your total score. Perfect score is 120, and if you get that, you are a real citizen, a first class asset to your community.

If you get above 90, give yourself a pat on the back.

If you get from 60 to 90—well, you still can

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hold up your head, but can't you get that score up a little?

If you get below 60, you know what to do.

Here's Another Quiz

While you are at it, might as well score yourself on your rating as a member of your local medical society:

Do you attend all medical society meetings when possible and take active interest in its projects? (35 points)

Do you read regularly your society's bulletins, news letters, your OSMAgram and your OSMA Journal? (15 points)

Do you accept committee appointments as a privilege and a responsibility, and take active part in your committee's work? (20 points)

Do you answer all your medical society and OSMA correspondence promptly? (10 points)

Do you remit dues promptly? (10 points)

Do you support the work of your grievance committee? (10 points)

Total possible points for this quiz is 100. If you didn't get a perfect score, you'd be surprised how easy it is to do so. All it takes is a little effort on your part.

Song of the Poet for The Longer Life

The aging rate of cells, tissues and organs is not the same for every human being, Dr. Theodore G. Klumpp of New York told a session on aging at the AMA's annual meeting. "Every physician sees individuals physically spent at 45, and others in full possession of their faculties at 65. What the responsible factors are we really don't know," said Dr. Klumpp, but he cited the following:

*"The horse and mule live thirty years,
And nothing know of wine or beers,
The goat and sheep at twenty die
And never taste of Scotch or Rye.*

*"The cow drinks water by the ton,
And at eighteen is mostly done.
The dog at fifteen cashes in
Without the aid of rum or gin.*

*"The cat in milk and water soaks,
And after twelve short years it croaks.
The modest, sober, bone-dry hen
Lays eggs for nogs, then dies at ten.*

*"All animals are strictly dry;
They sinless live and early die.
But sinful, ginful, rum-soaked men
Survive for three-score years and ten.*

*"And some of us, though mighty few,
Stay picked till we're 92."*

—Ciba Medical News.

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Each timed-release tablet provides:

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INTENSIVE POSTGRADUATE COURSES

STARTING DATES — FALL, 1959

SURGERY—Surgical Technic, two weeks, Sept. 21, Oct. 19. Surgery of the Colon & Rectum, one week, Sept. 21. Thoracic Surgery, one week, Oct. 19. General Surgery, one week, Oct. 26. Board of Surgery Review Course, Part I, two weeks, Oct. 5. Fractures & Traumatic Surgery, two weeks, Oct. 12.

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, Sept. 28. Vaginal Approach to Pelvic Surgery, one week, Oct. 12. General & Surgical Obstetrics, two weeks, Sept. 14.

MEDICINE—Electrocardiography, two weeks basic course, Oct. 5. Gastroscopy & Gastroenterology, two weeks, Sept. 14. Internal Medicine, two weeks, Oct. 19.

UROLOGY—Two-Week Intensive Course, Oct. 26. Ten-Day Practical Course in Cystoscopy, by appointment.

RADIOLOGY—Clinical Uses of Radioisotopes, two weeks, Sept. 21.

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In Our Opinion:

DR. PLATTER—ONE OF OHIO'S GREATEST

On June 18, Dr. Herbert M. Platter celebrated his 90th birthday. How? By handling the chores which go with the job he has held for so many years—secretaryship of the State Medical Board. Business was booming over at the Board's offices with the mid-year exams, etc., so Dr. Platter didn't have much time to think about such unimportant matters as celebrating a mere 90th birthday.

Nevertheless, the members of the State Medical Board felt that this event shouldn't go by unnoticed. They adopted a peach of a resolution attesting to his ability, knowledge and contributions to medical licensure over many years and said without qualification if Dr. Platter has any ideas about retiring as chief executive officer of the Board, he should immediately forget such a silly idea as that. Incidentally, they gave him a birthday dinner, a walnut humidor and 100 Corona-Coronas.

There is no man in Ohio Medicine more deserving of that kind of recognition. As long-time secretary of the Medical Board; as treasurer of the Ohio State Medical Association for many years, and then its president; as advisor and counselor to hundreds—yes, thousands—of neophyte physicians, and many older ones, as well, Dr. Platter holds a unique and lofty place in the ranks of the medical profession in Ohio.

Dr. Platter has had a grand career. He has been unexcelled in his job. He has won acclaim for his attainments, here and nationally. He has enjoyed life and in doing so has won an army of friends.

How about a toast to one of Ohio Medicine's greatest!

DOCTORS PROVE PERSONAL TOUCH IS INVALUABLE PR TOOL

Proof that the personal touch is an invaluable public relations asset came out in a Columbus meeting recently. The occasion was a conference of district field men of the Ohio Department of Highway Safety.

The traffic safety specialists were reporting the results of their calls on county medical society traffic safety committee chairmen. One of the field men described his experience by stating emphatically, "I have never been received with so much courtesy and consideration."

He told the meeting that every committee

Comments on Current Economic and Social Questions and Professional Problems: Suggestions Regarding Organized Activities

chairman he visited in his district received him promptly, sat down with him and discussed the subject with interest and enthusiasm. All this, he added, was in spite of the fact that he called on the physicians without prior appointment during their office hours. His appreciation was boundless.

Each of these doctors scored a PR home run. Here is another fine example of what individual doctors can do for good, constructive public relations.

GET A SUPPLY OF PLASTIC BAG WARNING LEAFLET

A warning leaflet concerning the potential hazards of plastic film has been issued by the Society of the Plastic Industry, Inc.

The pamphlet points out that recent reports indicate that young children playing with this ultra thin, limp film, become enmeshed in it and may suffocate themselves.

The Society suggests that parents keep the material away from children, and after it has served its purpose (as a garment bag, food package, etc.), that they dispose of it.

Copies may be secured from the society at 250 Park Avenue, New York 17, N. Y.

In our opinion a supply of these leaflets should be on the reception room table of every physician.

GROUP HEALTH ADVOCATES PLAN TO BACK BILLS

The grapevine has it that the Group Health Association of America, drum beater for closed-panel medical care plans, has hatched a legislative program which it hopes to have adopted in every state, which program will include:

A "community health bill" to establish the right of consumer plans to hire doctors.

A "hospital nondiscrimination bill" to protect closed-panel doctors from being denied hospital privileges.

A "medical antitrust bill" to provide civil and criminal penalties for "unlawful conspiracy against any form of prepaid plan which does not lower the quality of medical care."

A legal requirement that all tissue removed by surgery be examined by a pathologist, and that his report be filed with the state.

The addition of lay members to state boards of health and boards of medical examiners.

A free hand for state governors to appoint medi-

cal members to boards of examiners without "the influence of organized medicine."

No. 1 on this list was enacted by the present Ohio General Assembly—Amended Sub. Senate Bill 461.

If there are to be further tests in Ohio with regard to the GHAA list of legislative proposals, the medical profession must be ready to express its opinions and back them with action. Probably the place to start is at the polls when members of the General Assembly are being picked. No General Assembly can be any sounder on medical-health matters than its individual members. These matters should be kept in mind, come the general election in 1960.

BETTER MAKE A MEMO OF YOUR ASSETS

Because of its many ramifications, the average estate of the average physician is a complicated thing. Unraveling it often provides quite a chore for his widow and her attorney.

In our opinion, it would be wise for each physician right now to provide himself with notebook into which he can enter a check-list of his assets, his insurance policies, his bank and savings accounts, and pertinent data about his practice, his office, his investments, commitments, etc.

This just makes good sense, don't you think?

PHYSICAL EDUCATION QUESTIONS ANSWERED

Many of the problems which arise in the minds of parents when their children participate in school athletic programs and physical education have received careful study with resulting sound advice in "Answers to Health Questions in Physical Education," published by the American Association for Health, Physical Education, and Recreation.

This 24-page report, prepared through the joint efforts of the American Medical Association and the National Education Association to define health responsibilities of coaches and physical educators, should be of real interest to parents, school administrators, community youth organizations, and students.

Concise and authoritative advice is given on infection and the spread of disease, responsibility for first aid, smoking and drinking, use of "pep pills," exercise and the healthy heart, precautions and responsibility in cases of injury, and dozens of other questions and situations which could arise in a normal school program of athletics and physical education.

Copies of the booklet are available for 50 cents through the Association for Health, Physical Edu-

cation and Recreation, 1201 Sixteenth Street, N. W., Washington 6, D. C.

It is suggested to each physician that he get several copies for his reception room table and that he recommend to parents that they write for a copy.

GIVE YOUR PATIENTS CHANCE TO READ TODAY'S HEALTH

As a result of action by the House of Delegates of the AMA at the recent Atlantic City meeting, all dues paying members of the AMA will receive as a part of their membership benefits, *Today's Health* and any one of the AMA specialty journals, in addition to *The Journal of the AMA* and the *AMA News*. When members will begin receiving the two additional publications will be decided by the Board of Trustees.

In making this recommendation, the AMA Board of Trustees said:

"It is our earnest hope that the membership will receive this important publication designed for the public and make it available to their patients by displaying the magazine in their waiting rooms."

In our opinion, this is an excellent suggestion. See that *Today's Health* occupies a prominent place on your waiting room table.

STUDY ON AUTOPSIES COULD PROVE MUCH WORTHWHILE

In our opinion much worthwhile could result from action taken by the AMA House of Delegates this year in adopting a resolution relating to the laws dealing with dead human bodies. The present laws on autopsies and relating to the matters in most of the states probably are in a state of confusion. The situation in Ohio can be improved. The public is not sufficiently informed on such matters. The AMA action was as follows:

"Resolved, That the AMA House of Delegates instruct the appropriate officers, committees or councils to:

"(1) Initiate and implement efforts to modernize the body of state law dealing with the dead human body, and advocate changes in the law so that pathologists, coroners, and medical examiners will not be in conflict with the law in the several states when conscientiously performing their duties in the pursuit of justice, in determining the causes and manner of death, the protection of the innocent, and the deterrence of crime; and

"(2) To inform the public in general of the necessity and advantages of model laws authorizing properly performed autopsies with removal of tissues for study, and further inform the public that autopsies are essential to the acquisition of medical knowledge and that such laws also might well authorize tissue removal for eye banks, aorta banks, etc.; and,

"(3) Cooperate with the Committee on Medicolegal Problems, and, the AMA-ABA Liaison Committee to further the purposes of this resolution."

The studies which will be made should produce something which will be very helpful to all the states in meeting their individual problems in this field.

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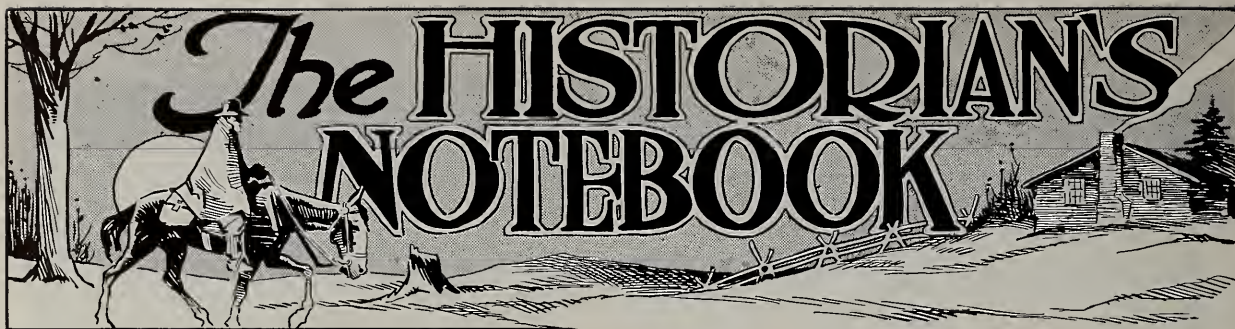
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Northridge, Calif.



A Short History of Medicine and the Physicians Of Delaware County, Ohio

M. S. CHERINGTON, M. D.

PART I

IT is not certainly known just who may have inhabited this area which now comprises Delaware County, Ohio, in the period before the Mound Builders, and they have left little to tell us of their civilization, especially in regard to sickness and their methods of treatment. The Indians followed the Mound Builders and we know that they had their Medicine Men who practiced a sort of psycho-therapy and combined it with use of massage, water treatment or cures, the use of herbs, berries, roots etc., that they, through the centuries perhaps had learned, gave benefit in some conditions, but *why* they knew not. Even the early settlers had at times found it necessary to seek their help. The Indians used the Mineral and the Sulphur Springs for treatment by drinking the water and they also used a sort of steam treatment from a pit containing hot rocks that, then, had water slowly poured over them and covered by a teepee.

Early Concern for Doctor

The pioneer settlements of 150 to 200 years ago were usually made by one or more families, and in fairly well separated areas. The teacher, minister, lawyer, etc., were not much needed but many settlers were much concerned as to the availability of a doctor.

When the Queen of Sheba, from Southern Arabia, came to visit King Solomon, she brought with her a physician, and the great medicinal agent, the Balm of Gilead. The piety, wisdom, glory and courtesy of Solomon greatly impressed her. Upon her return to her own country she sent, contrary to the laws of her land, the great medicinal tree so long known to her kingdom, 800 miles away, to this admired ruler, to be planted

Presented before the Delaware County Historical Society
April 27, 1959.

The Author

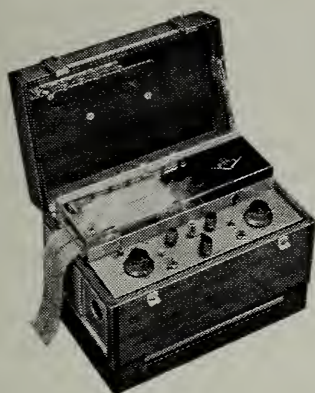
● Dr. Cherington, Delaware, is a member of the staff of Jane M. Case Hospital.

along the river Jordan. The tree grew, increased, and furnished medicine to Palestine.

Jeremiah, 600 years after, and 600 years before the Christian era, said, "Is there no Balm in Gilead? Is there no physician there?" And so, one of the first queries of the emigrant is, Biblically speaking, "Is there Balm in Gilead? Is there a physician there?" Or in other words, "Is there a doctor within reach?" Now "within reach" in this area sometimes meant a one to even four days' ride. As we will see later, such a one as Dr. Lamb often rode as far north as Portland, now Sandusky, and south to Chillicothe.

The settlers of that early day merely asked if the person at hand was a doctor. They did not have to worry about having to select or get the services of one who came under a special type of practice or "ism." It was not until about 1824 that the first system presented itself. This was called the Thomsonian System, evolved by Samuel Thomson (1769-1843) who advocated that "heat was life and cold was death." He had prepared formulas from No. 1 to No. 6 to produce these results. Thus he steamed the patient outside and stimulated him inside with his No. 6 formula.

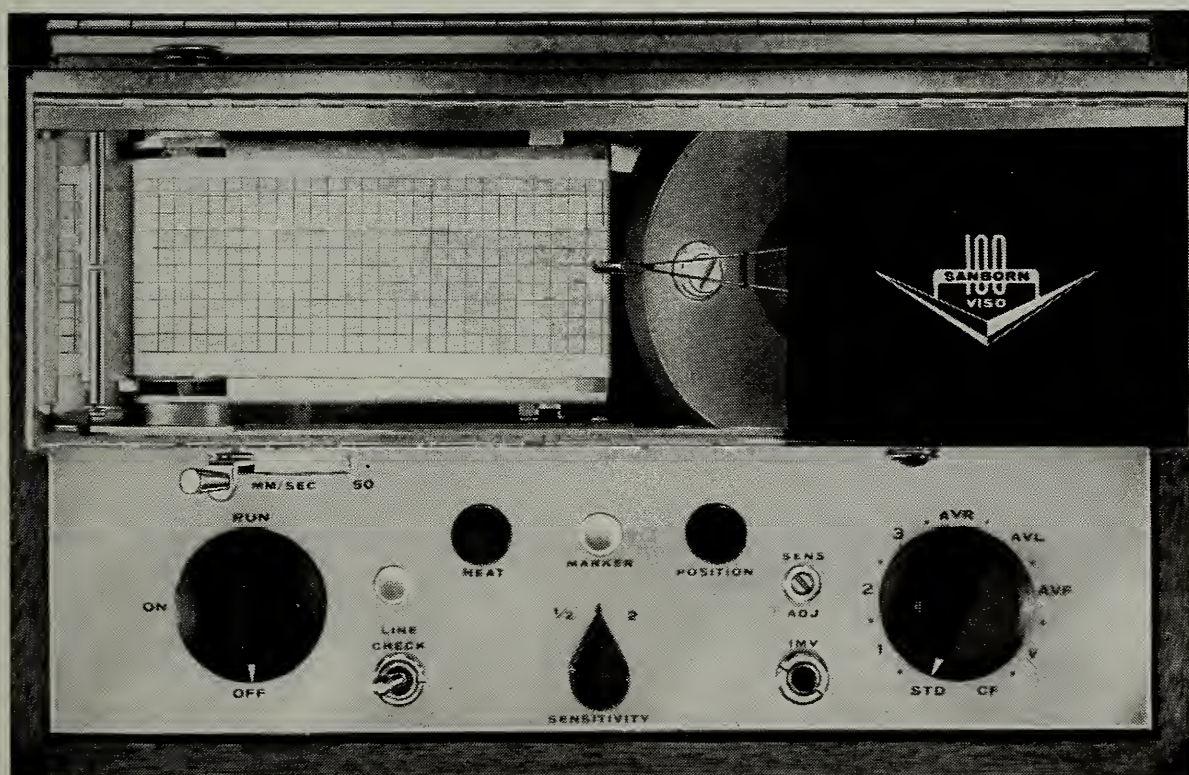
Thomson's book of theories and instructions were sold to families as well as to physicians. In a few years this system passed away but the steaming and bathing had made an impression which culminated in the erection of many large sanitariums in this and all lands. It is interesting to know also that one of the citizens of Delaware, a



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Mr. Horton Howard, bought the rights to Ohio and several Western and Southern states for the promulgation of this system and the sale of the books.

Advocates of the next system to appear were the Uroscopists, in 1838, who thought the kidneys were the source of all of our ills. This, too, soon passed away but served a good purpose as it stimulated more thought and investigation on the part of the regular school.

Schools of Other Systems

I do not know when the Eclectic School of thought made its appearance here but it was not long afterwards. An Eclectic School or College was established at Worthington, in 1830. Dr. J. J. Steel was president and Dr. J. G. Jones was the dean. The latter was a partner of Dr. Case, the husband of Mrs. Jane M. Case who, through her will, provided money for the establishment of our Hospital. Also Dr. J. A. Little, a resident of our county, was associated with them for a while. He was a student and a teacher and later became a member of the regular school. This College and system had a great influence in this area. Later it was moved to Cincinnati and called the Eclectic Medical College. Today there are none of such schools left. It was an expansion of the herb system and Indian medicine.

The Homeopathic doctrine made its appearance in about 1850, and has had a representative in this county ever since. Today there remains only one such school, the Hahnemann Medical College in Philadelphia, and it teaches all regular school and modern doctrine in addition.

Then the many specialty groups began to appear and the masseurs and the osteopaths had become established. These last and their method, however, had been known to the Chinese, Hindus, and Brahmans long before the Christian era. Finally, at the close of this era of change, we have the appearance and acceptance of the lady physicians, in 1840, who have played an increasingly important part up to the present time.

It must be remembered also that the lone physician of those early days, besides doing the work of a doctor and a surgeon, had to combine with it that of a dentist and a druggist. He also was regarded as the embodiment of learning generally, and held the respect of the people in all matters.

In dealing with the History of Medicine in Delaware County and the individual sketches of the doctors who have served here we are greatly indebted to one man, Dr. Silas W. Fowler, who seemed to be of a literary nature, and what has been written through the years has been done by him. He was here as a young man, in 1880, and wrote the first account on this subject for the 1880

Delaware County History. Again, when Judge Lytle wrote the Centenary History, in 1908, he asked him to write that part and bring it up to date. Dr. Fowler published his own little book two years later, 1910, on The History of Medicine and Physicians of Delaware County, Ohio, at the solicitation of the County Medical Society and the Drake Memorial Association. As he stated, he could not have done this had it not been for the help of the older doctors in 1880, a few of whom went back 50 years to 1830, and practiced and mingled with those who preceeded them.

Then again, after 28 years, Dr. Fowler repeated this same procedure. In his early days of practice he was intimately associated with the scholarly and renowned Dr. Ralph Hills, the son of Dr. James H. Hills who had settled in Delaware in 1822, and Drs. T. B. Williams, W. T. Constant, and John A. Little, who often met in the studio of Dr. Ralph Hills to listen to the stories of the pioneer, so graphically related by him, as well as to hear the history of those who came later.

Before taking up the individual physicians I want to speak briefly of the Medical Society History.

Medical Societies

It has been said that "associated action constitutes the mainspring—the controlling motive power of society." Thus it was with the pioneer practitioners of this county, who saw the extreme need for associated action. So in 1848 they set about to form a medical society. Those present were Drs. Ralph Hills, Abram Blymyer, J. M. Cherry, M. Gerhard and a few others whose names are lost. This was to be known as the Delaware County Medical Society. Dr. Hills was the president and Dr. Blymyer was vice-president. At this meeting Dr. Blymyer read a paper on "Milk Sickness and Its Treatment." Meetings were to be held every three months.

During the years 1848, '49, and '50 they met fairly regularly. In 1851 new members were added and on the 15th of June, 1852, they made a permanent organization. Among the many articles in their constitution was one that declared that "no person could be admitted to membership who was not fully orthodox in his professional beliefs and practice." The society after a few years for some cause went to sleep, only to be revived again in 1868. After the Civil War new life seemed to be given to the society and the profession.

The Ohio State Medical Society convened in Delaware in May, 1856, while Dr. Ralph Hills was the editor of the *Medical Counsellor*, the first weekly medical journal published in the West, and which he had established in 1854.

(To Be Continued in September Issue)

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PERRY R. AYRES, M. D., *Editor*

CHARLES S. NELSON,
Managing Editor — Bus. Mgr.

R. GORDON MOORE,
Asst. Managing Editor

Practical Considerations in the Management of Psychosomatic Problems in General Medicine

ZALE A. YANOF, M. D.

ONE of the greatest satisfactions available to the physician in both general and internal medicine is the attainment of practical skill in the management of the psychic difficulties that beset his patients. The widespread occurrence of emotional disturbance in all fields of medicine needs no reiteration or amplification. The physician who is as adroit in the management of anxiety and depression as he is skillful in the treatment of a patient with myocardial infarction or bleeding peptic ulcer is not only a superior clinician but also, and unlike his strictly organic brethren, a practitioner of total medicine. Those physicians who refuse to assign as much importance to the psyche as to the soma, will in time be outdated and outmoded not only by their psychosomatically oriented colleagues, but also by the public which more and more is demanding that physicians understand and treat their patients' disordered emotions.

The medical physician has many advantages and is better fitted than the psychiatrist for the management of the lesser and more prevalent psychiatric ills. He sees the psychosomatic patient early in the course of the disease when the causative psychogenic factors are most recent, superficial, and amenable to therapy and he is thus in a position to treat them when they are most accessible. With his diagnostic skill and investi-

The Author

● Dr. Yanof, Toledo, Diplomate of the Board of Internal Medicine, is a member of the staff of Flower Hospital.

gative facilities available to him, he can competently assay the organic factors. He is versed in the knowledge of disordered organic physiology which is usually present in psychosomatic disorders and he is expert in somatic therapy. He can concurrently treat angina pectoris and co-existing anxiety while the psychiatrist can treat only the anxiety.

Somatic Diagnosis

The clinician's first approach to the psychosomatic patient should be on an exclusive organic basis. In psychosomatic medicine there is no single procedure more important than the complete examination and adequate explanation of the findings to the patient. All necessary diagnostic procedures and tests should be done to establish or eliminate any suspect organic illness, with the thought ever in mind that organic disease can co-exist with emotional disorder. The constantly complaining hypochondriacal patient with the common psychogenic symptom of indigestion can also be harboring an early carcinoma of the stomach.

One negative examination or test should never

Presented at the Fifth Annual Meeting of the Academy of Psychosomatic Medicine, New York City, October 9-11, 1958.

close the door to organic disease. Certain organically suggestive symptoms, as indigestion, chest distress, and abdominal pain, even though of obvious functional origin and negative to all tests, should constantly be suspect of the worst as they can at a future date always turn out to be the worst. Chronic diarrhea with negative findings and being treated with psychotherapy, should be periodically checked for amebae—or someone else may find the amebae. Examination and re-examination should be the watchword of the psychosomaticist.

If all examinations are negative, it is commonly held that the patient's complaints are functional. This generalization, that symptoms not substantiated by positive findings are always psychogenic, needs revision. Oftentimes a patient with negative findings will have none of the signs nor give any indication of emotional disorder. Psychotherapy in such a patient is futile and justifiably antagonizes the patient.

We should consider our present physical diagnostic methods—as comprehensive and advanced as they may appear to be—as in reality crude and still primitive. This will become apparent in the coming age of biochemical diagnosis.

A portent of things to come may be seen in the work of Wróblewski¹ and co-workers who has recently shown with his transaminase enzymatic studies that liver damage can be present for some time before biopsy of the liver shows altered structure. Altered physiologic function can occur without demonstrable altered structure. The astute clinician, by careful psychic evaluation and somatic study, should decide for himself if a symptom with negative findings is nevertheless on an organic basis—and not of emotional origin.

Diagnosis of Anxiety

The first order of business in the psychic evaluation is to determine whether the patient has anxiety or depression, or both; and if both, which is predominant. This differential diagnosis is essential, because treatment for one is entirely different from treatment for the other. Misdirected depressive therapy in an anxiety case will heighten the anxiety, and anxiety measures in a depressive will aggravate the depression. Further need for differentiation between anxiety and depression rests on the fact that, generally speaking, each requires a different form of psychotherapy. Depressives do not tolerate, at least in the early stages, psychic probing and exploration of traumatic issues or conflict. Surfacing of psychonoxious material aggravates depression.

The psychosomaticist will have no difficulty in recognizing anxiety. Viewed in broad perspec-

tive, anxiety is a condition of heightened tension—a fear equivalent—usually associated with a feeling of apprehension. Tenseness, restlessness, irritability, uneasiness, and ordinary nervousness, are the outward signs. Some confusion may arise in the recognition of its equivalents or aberrant forms.

Thus the anxiety patient may present himself without any obvious external signs of heightened tension, but with somatically displaced anxiety—as precordial discomfort with palpitation of the heart, vertigo, respiratory difficulties, or gastrointestinal disturbances—which in effect are actual physiologic changes resulting from anxiety. The practitioner should also recognize that anxiety at times will present itself only covertly with only headache or muscular pains as presenting symptoms.

Diagnosis of Depression

The diagnostic delineation of depression is more involved. If the patient enters in an obvious state of sadness with self-condemnation and weeping and wringing of the hands, then there is no problem. The problem is to recognize the covert or masked depressive—of which there are many—who denies that he is depressed and shows no outward signs of a depressed mood. Like anxiety, depression can, and usually does, masquerade in the guise of somatically referred symptoms, running the whole gamut from headaches and dizziness through the stomach and bowel and down to the bladder, with particular proneness to hypochondriasis.

Depression can also be hidden under an anxiety state, various neurotic reactions, and phobic and obsessive-compulsive reactions. In severe depression, anxiety can be as intense as the depression. Even the mild depressive has anxiety.

For the diagnosis of covert or masked depression, one must look for the subtler signs of psychomotor retardation—a slowing of mind and body. Fatigue occurring soon after arising, lack of energy, and insomnia of the early awakening type should excite initial suspicion. Then listlessness—physical and mental inertia; reduced interest in work, family, and friends—general indifference, and the diagnosis is made. Other depressive signs of early psychomotor retardation are: increased effort in doing things and inability to finish; reduced zest and vitality, emotional flattening, absence of optimism in thinking and feeling, inability to concentrate, impaired memory and mentation, loss of quick and facile thinking, loss of self-confidence and feelings of inferiority. Obesity and compulsive eating are often a defense facade against depression.

With due consideration to the insidious signs

of psychomotor retardation, the diagnosis of depression should offer no problem. If necessary, a therapeutic test can be done. Depressives are made worse with tranquilizers and tolerate barbiturates only in small doses. The reverse is true for anxiety. Anxiety states—with or without somatization—that do not improve on barbiturates or tranquilizers, should be suspected of representing masked depression.

Depression is more apt to accompany organic illness than anxiety—a somatopsychic reaction. Patients with brain tumor, multiple sclerosis, hypothyroidism, and cancer of the pancreas frequently exhibit depression even before the signs and symptoms of the organic illness become obvious. In depression it is especially imperative to continue to rule out organic etiology and to re-evaluate at every opportunity the diagnosis of primary depression vs. organic disease.

Depressions are variously classified as neurotic, situational, reactive, endogenous, nonpsychotic, or psychotic. This is an attempt at etiologic arrangement, but there is serious question whether depression can be caused solely by environmental stress. Depression from mildest to the most severe is in reality only a quantitative difference. For the general physician a working classification should be based on those which he can treat and those which should be referred for psychiatric care. On this basis, depression can be classified as mild, moderate, and severe. Most mild depressions and some moderate depressions can be adequately handled by the general physician. The severe depressions need psychiatric care.

Chemotherapy of Anxiety

The drugs available today for the treatment of mental disorder are best adapted to the treatment of anxiety. The tension-relieving or anti-anxiety drugs include the sedatives of the pre-tranquilizer age: barbiturates, chloral hydrate, bromides; and the present-day so-called tranquilizers: the phenothiazine derivatives, rauwolfia alkaloids, and meprobamate. These sedatives, the old and the new, provide a chemical control for anxiety—mild and moderate—or the severe states of psychomotor excitement, agitation, panic, and mania. Basically, the antianxiety drugs are inhibitory. They decrease psychomotor activity and lower responsiveness to endogenous and exogenous stimuli.

There is a wide choice of drugs for the relief of anxiety, with new tranquilizers in constant arrival and even more promised for the future. Present dispensing has shifted markedly to the

new tranquilizers, despite the fact that there is still much doubt whether many of the newer drugs are very much better than the older ones. As an example, bromides, though in disrepute and unfashionable, are still the best in some tension states. Chloral hydrate still has a unique place in certain types of tension and insomnia. In actual practice, I have found very little difference between the barbiturates and the tranquilizers in the treatment of the usual anxieties in office practice—except the tranquilizers are more expensive.

The introduction of the tranquilizers undoubtedly marks a great event in the treatment of mental disorder, both in their therapeutic power and in their portent of greater things to come in the chemical control of the abnormal (and perhaps even "normal") mind. At present, however, the tranquilizers are best adapted to the treatment of the psychotic or psychotomimetic states that display psychomotor excitation with panic and anxiety, as in manic states, psychotic delirium, and acute schizophrenic episodes. They do a remarkable job of quieting these patients. In this respect they are an advance over the barbiturates, as barbiturates when used in massive doses are too narcotizing.

In the nonpsychotic emotional disorders they relieve anxiety and tension in the same manner as the barbiturates, but with the alleged difference of not dulling mental acuity. The former claim is established, but the latter is open to question; at least in my experience patients are dulled, even with meprobamate.

Very few people hesitate to admit that they take Miltown® or Equanil® nightly for sleeping, while the taking of Nembutal® or Seconal® carries social opprobrium and is usually concealed. The general feeling is that the tranquilizers are harmless and nonhabituate, which any astute clinician knows they are not. Likewise, physicians think nothing of keeping patients on such tranquilizers as Compazine® or Trilafon® for months while with the barbiturates they were more cautious, thinking of the addictive factor and the toxicity dangers with long usage.

The tranquilizers produce apathy and decrease drive. In some patients this may be desirable but in many they serve as an escape from problems that need solution and act as a barrier to self-advancement. A case in point is a patient who, tranquilized for three years, lost the need to solve a basic personal problem and when after developing hepatitis all drugs were interdicted his personal conflict surged to consciousness, throwing him into an acute totally disabling anxiety.

Many patients react adversely to tranquilizers. Those with a depressive background are worsened.

In this respect rauwolfia alkaloids and chlorpromazine are the worst offenders, while Equanil, Trilafon, and Stelazine® are said to be the least inhibitory. Tranquilizers can produce bizarre reactions, as turbulence or increased anxiety, excessive euphoria, and feelings of depersonalization. Somnolence, parkinsonism, and hypnotic effect are not uncommon. Some are hepatotoxic and agranulocytic.

In general medicine the tranquilizers do best in a hyperactive and hyperenergized individual with pure anxiety and no mood depression. Other indications for general medicine are: acute and severe anxieties and toxic delirium where large doses of barbiturates would be too narcotizing; acute anxiety and agitation of older people who are frequently intolerant to barbiturates; and clinical states where the associated muscle relaxant and autonomic effects are also desired.

As to which tranquilizers to use there is great confusion, because of the ever-growing number and premature and extravagant claims. Much time is needed for the final decision as to proper use and dosages of these new drugs.

The best course at present for the clinician would be to use only a limited range of drugs, both old and new, rather than experiment ineffectively with too many. He should become adept in the handling of a good short-acting, medium, and long-acting barbiturate; these together with one or two of the less potent tranquilizers, as Compazine, Miltown, Trilafon, will prove to be a satisfactory range of sedatives to use in clinical practice at the present time—at least for the anxieties, neurotics, and normal patients of general medicine.

Chemotherapy of Depression

The chemotherapeutic objective in depression is to stimulate or excite inhibited mental and emotional functions. This is accomplished with the group of drugs variously referred to as cerebral stimulants, analeptics, excitants, mood elevators, euphorants, and psychic energizers. Chief among these are the sympathomimetic amphetamine and allied compounds, as Benzedrine®, Dexedrine®, Desoxyn®, and the newer ones as Ritalin®, Meratran®, and benactyzine. In contrast to sedatives, they increase psychomotor activity and enhance sensitivity to external stimuli. Their usefulness is limited to mild cases of depression. Thousands of individuals take them daily as a mild euphoriant and escape from the daily ennui of living.

In general medicine the stimulants are of great value as mood elevators and energizers in

mild depression and its allied states as psychogenic fatigue, hypoenergization, moodiness, and physical and mental inertia. They are also used with great advantage in such diverse conditions as convalescent asthenia, postcoronary depression, and in the common mild to moderate depression of older people. Troublesome side effects are increased tension and insomnia which at times can be relieved with small doses of concurrently administered barbiturates.

The stimulants are totally ineffective in severe depression. The problem here is that severe depressives also have heightened tension and the stimulants when given in sufficient dosage further increase and potentiate this tension with the net result of a more disturbed patient. While this increased tension may be controlled with sedatives, in the process the sedatives worsen the depression. Furthermore, stimulants aggravate the disabling insomnia that plagues the severe depressive. There is no effective drug for severe depression or depression of any noteworthy degree. Convulsive therapy remains the only known specific remedy.

If the physician undertakes to treat a case of moderate depression which may not appear to be too severe, he must finely balance the administration of sedatives with stimulants. Barbiturates are the sedatives of choice. Leo Alexander advocates meprobamate—which he combines with benactyzine—as least inhibitory of the tranquilizers.² The phenothiazine and rauwolfia derivatives are contraindicated.

Moderate depression can usually be relieved if the insomnia can be eradicated—a formidable task, as heavy doses of hypnotics may produce sleep but also result in increased depression on awakening. If there is no response within a reasonable time, electroconvulsive therapy by a psychiatrist is indicated and often only a few treatments are required. The possibility of suicide is always present and too often occurs when least expected.

Recently, Marsilid® has shown itself in many cases to be a remarkable stimulant and psychic energizer. Undoubtedly it is the nearest approach yet to the ideal mood elevator. But unfortunately, its alleged or presumed hepatotoxicity prohibits its use in the lesser depressions of general medicine. It should be used only in severe illness, and then only if facilities for careful liver function study are available.

All psychotropic drugs—both for anxiety and depression—should never be stopped abruptly. They should be withdrawn slowly, as there is always a certain amount of accrued emotional drug

dependence which is best dissolved by gradual discontinuance.

Limitations of Drug Therapy

With the enthusiasm now raging for the new mental drugs, it would be well, for the maintenance of proper perspective, to critically examine the present limitations of mental chemotherapy. The chemical treatment of the mind consists of only two classes of drugs—sedatives and stimulants, which means that the clinician can only offer his patient sedation or stimulation—an impoverished situation at best. Actually, he is restricted even further because patients can be sedated more effectively than they can be stimulated. And these actions are not entirely clinically selective, because sedatives worsen depression and stimulants worsen anxiety.

Anxiety and depression, comparable to the hectic fever of infection, are only one of many outward manifestations of basic underlying mental dysfunction, the causes of which are little understood and for which no effective drugs have as yet been devised. Present-day chemotherapy of anxiety and depression is analogous to lowering fever to lessen discomfort—in which the anxiety and depression are the fever—without arresting the causal infection.

In the psychoses the two most potent drugs, reserpine and chlorpromazine, do not alter the basic mental defects. All drug therapy available in psychiatry today has not significantly increased the rate of complete and/or social recovery. Patients are quieter; more manageable; there is less morbidity. Only lesser disturbances are relieved at a greater rate than obtained spontaneously.

The psychotropic drugs have no effect on the learned responses, such as well established conditioned reflexes, and they cannot obliterate the deeply learned responses that underlie neurotic behavior. They cannot change character or basic personality structure. All sedatives, hypnotics, and tranquilizers impair mental acuity and motor response in healthy individuals. The analeptics stimulate, often at the cost of increased anxiety and rebound depression. They are mostly ineffective in depressive states and obsessional reactions. Drug responses to the same drug can vary from week to week in the same individual.

Mental drugs vary widely in their dosage requirements from person to person. Paradoxical reactions are more common with psychotropic drugs than with any other class of drugs. The cholinergic, adrenergic, and autonomic actions inherent in most mental drugs are not always desirable, and can at times outweigh the beneficial effects. In general medicine there is always the

danger of drug dependence, habituation, and addiction. Living in a fool's paradise, apathy, loss of drive, submergence of problems that need solution, decreased mental power, hasty decisions, impulsive thinking and behavior, chronic euphoria, loss of defenses, are some others.

There is a growing opinion held by many people that the chemical treatment of the mind is morally wrong and certainly not to be encouraged. But the mental drugs, even with their limitations, can spare many patients from unnecessary, avoidable, and physically exhausting mental suffering. As such, it is the doctor's duty to prescribe them.

Psychotherapy

Most internists and general physicians tend to associate the word psychotherapy with some sort of abstruse, ill-defined, and quasi-medical procedure that is difficult in its practice, time consuming, and often futile. As their medical training is basically organic in orientation, a type of therapy that is psychologically directed can engender feelings of aversion and hostility.

But there is a type of psychotherapy that is suitable for physicians in general medicine and effective for their patients. The core of psychotherapy is a warm, positive type of doctor-patient relationship. Any physician whose patient respects and/or admires him, is in effect already a successful psychotherapist, inasmuch as by this respect and admiration he is in a position to beneficently influence the patient. The first stage in psychotherapy is the establishment of such a relationship. All successful physicians for ages have accomplished this without referring to it as psychotherapy.

The next stage, rapport, goes a step further, in that when a doctor is said to have rapport with his patient, the patient will talk to him freely and without restraint, as to a close friend. The patient in rapport regards his physician as an authoritative, protective, and omnipotent figure—an ideal situation for successful therapy. Going even further, there is a type of transference where the patient may become totally dependent on the physician, or even become amorously attached. The judicious practitioner learns to recognize and avoid this type of transference. Rapport is all-important and also influences organic therapy and is the equivalent of the placebo effect.

If with rapport the therapist effectively adds suggestion, encouragement, and reassurance, a good part of the psychotherapy is already accomplished. This is generally referred to as supportive therapy, and in many cases is all that is needed.

If the patient does not improve with suppor-

tive therapy then a search is instituted for environmental or personal stresses—stage three of the psychotherapeutic process. Arbitrarily and as a working scheme these can be divided into interpersonal environmental stress and intrapersonal stress. The former denotes such interpersonal environmental stresses as marital difficulties, social maladjustment, and family strife. Although time consuming, the resolving of environmental stresses can usually be handled by the clinician.

The physician who likes and understands people and has an insight into life's problems, can qualify as an expert counselor and aid and direct the patient through guidance, interpretation, persuasion, and re-education, in the resolution of his interpersonal problems. If the situations which produce anxiety cannot be altered, he will teach his patient to revise his attitude towards them. At the same time the patient is afforded an opportunity for two important psychotherapeutic procedures—ventilation and catharsis. Essential, and frequently neglected, is rapport with the patient's husband or wife, father or mother, and often just one conference with the closest relative or involved person is sufficient and can spell the difference between therapeutic success and failure.

The practitioner could stop his psychotherapy at this point and refer everything else to a psychiatrist. If he wants to go further, he can consider intrapersonal stresses. This encompasses conscious or unconscious conflict—residing solely in the self and bearing no immediate direct relation as such to the environment—such as frustration, dissatisfaction, unrealized goals, and maladjustment, and revealed in such responses as feelings of inferiority, insecurity, emotional immaturity, guilt, self-depreciation, hostility, and aggression.

Even here the clinician who has a basic knowledge of psychodynamics and knows his patient well can usually determine the source of the conflict and apply remedial reconstruction and rehabilitation. This can be done by such relatively uncomplicated guidance as encouraging the patient to face his problems openly and honestly, in an effort to find some way of changing his reaction to unalterable circumstances, and by teaching his patient to see the necessity of adjusting to his limitations rather than to struggle against insurmountable odds. Psychodynamic analysis and therapy extend from a low to a very high range of depth and complexity. The practitioner will be soberly influenced by his own limitations of inclination, ability, and time.

Not all patients need probing into their minds or lives. There are patients with nonpsychotic

anxiety or depression which do not necessarily arise from situational stress but from endogenous causes, as yet unknown and undetermined. Psychotherapy, outside of emotional support, in such cases is futile. Conversely, there are stress situations proffered by the patient which are not real, but which arise from the distortions of anxiety-laden minds. In the former and in the latter, the clinician must determine whether a given stress is related or unrelated to the psychic disturbance. Dull normals who are unsophisticated respond best to reassurance and suggestion. Care must be exercised in probing depressives, as release of traumatic material aggravates depression. The depressive has very poor defenses.

As part of the psychotherapeutic program the physician should decide in advance how long the patient should be kept on drugs, and should so inform the patient. Except for the hopelessly ill, the insane, the infirm, and the aged, an attempt should always be made to teach patients once they are adequately controlled, how to live without psychotropic drugs. This will eliminate the countless refills that can go on for years and help break the evil of mental drug dependence.

The practitioner will save himself much grief if he refers to a psychiatrist such cases as psychopathic personality, inverse sexuality, fixed personality disturbances, ingrained character defects, rigid neurotic patterns, obsessive-compulsive states, severe and fixed emotional disorganization, and deep-seated anxieties.

A practical consideration is knowing what type of psychiatrist to refer a patient to. There is more than one school of thinking in psychiatry. They vary from the analysts and strictly psychotherapists who utilize no somatic or chemotherapy to those who use only organic methods with very little psychotherapy. In between are the various eclectics. The physician should familiarize himself with the various schools and their representatives in his community, so that he will be able to determine which psychiatrist will do best for which patient.

In the overall approach to the patient with emotional and/or organic illness, the physician should not rigidly confine himself to just one school of thinking or to just drug therapy or to just psychotherapy. And his therapy should never be without the warm positive doctor-patient relationship—the core of the highest type of medicine.

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Health and Wholeness

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WHOLENESS in regard to health of man is more than the sum of all his organs at the prime of normal functioning. Wholeness, I would say, is an intimately inter-related, inter-dependent, interaction of mind and body that aims to maintain at all times and in any kind of stress, a state of balance.

It is strange that the very science that so often is blamed for losing itself in the most minute details of human behavior, should have helped us to gain a picture of the whole personality. Dynamic psychology, the analytical examination and evaluation of motivation and response has furnished us with the architectural blueprint of the inner personality which we now can bring into relation to the physical, that is, the organic functioning by way of the neuro-endocrine systems. Thus we have come to see an individual in his entirety.

Illness a Faulty Adaptation

It was Claude Bernard, the great French biologist, who at the beginning of the last century, having discovered the glycogenic function of the liver and the digestive action of the pancreatic juice, came to the conclusion that illness was the result of a faulty adaptation to noxious agents. He stressed the point that this adaptive defense reaction which originally was meant to help the organism in his battle against destructive elements, could become a damaging force itself. This theory has been substantiated lately by a number of researchers so that we see for instance, that when a system responds to danger, with an output of adrenalin, which in turn brings about a rise of the blood pressure, an over-adaptation to a threat, real or imaginary, may overstimulate the sympathetic system; or may, as in a state of anxiety keep up a pressure over a prolonged period of time if an individual fails to demobilize because in such cases, a threat continues to rule the mind of an individual.

The Psychosomatic Concept

Psychosomatic medicine studying the effect which disturbing emotions have on the chemistry, and its effect on the physical functioning of an organism, provides us increasingly with more data of the interrelationship between soma and psyche. Indeed, more and more do we see illness to be a destructive assault on the whole and while illness

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may be of physical origin, most of the time, it develops in the psyche first and then affects the body. Even in the case of a bacterial infection, we see that the resistance against an illness differs with each individual, and is indeed aggravated by self-destructive forces within the personality.

What is the nature of these differences? Do we humans react differently at different times in our life, or are different personalities reacting differently to similar stresses? While it is true that our attitude physically and psychologically, changes within the span of our life, and that our resistance may lessen or grow, the basic reactions toward life situations are, however, anchored within the personality and are specific for an individual.

The Four Temperaments

Let us therefore take a look at the differences in personalities: Although it is no easy matter to classify human beings and their behavior, we find nevertheless, about four different distinct responses to life situations which correspond approximately with the four temperamental types Hippocrates already had described. In his later, not too well known, experiments Pavlov conducted first on dogs and then on people, he arrived at observations which closely approximated Hippocrates' four temperaments:—

- | PAVLOV | HIPPOCRATES |
|---|-------------|
| (1) Strong | |
| Excitatory Type corresponds with | Choleric |
| | Temperament |
| (2) Lively Types correspond with | Sanguine |
| | Temperament |
| (Pavlov found the Lively types to show a purposeful and controlled reaction to identical stresses.) | |
| (3) Calm Imperturbable Type resembles | Phlegmatic |
| | Temperament |
| (4) Weak Inhibitory Type corresponds with | Melancholic |
| | Temperament |

Four Emotionally Different Personalities

Clinically and psychosomatically, one should not find it difficult to accept Pavlov's classification,

except that from a psychodynamic point of view, it would perhaps be more meaningful to name.

- (1) The strong excitatory type—a *hostile aggressive personality*.
- (2) The lively (The one showing purpose and control)—an *aggressive adjusted personality*.
- (3) The calm imperturbable—a *passive, dependent personality*.
- (4) The melancholic—weak inhibitory,—a *withdrawn regressive personality*.

This classification, even considering the shortcomings which any attempt to classify human beings must have, is of more than just theoretical importance. We find that we all deal with life situations more or less specifically, that is in accordance with our conditioning, and that such dealings, the freedom of actions, or the inhibition of them—a well-balanced release of energies or the blocking of them, in a last analysis determine an individual's state of health or his attitude towards his illness. The body reaction, the blood chemistry, in a hostile aggressive personality may be similar to that in a passive regressive personality, except when exposed to continuous stress, fundamental differences in bodily functioning may develop.

The first two groups—one showing an over-alertness, an over-reaction and consequently an over-production of the fighting hormones; the other, with a more adjusted attitude, responds emotionally when confronted with a problem neuro-endocrinologically differently than groups three and four. Perhaps one could also say that because they react differently towards life situations, their systems are stimulated and respond differently.

Fight or Flight

Groups 1 and 2 react to a threat by either FIGHT or FLIGHT (a term Cannon introduced). These individuals take action, the first too impulsively perhaps, the other more thoughtfully, but both "Won't let grass grow under their feet." They deal with a problem realistically. They can make decisions and they can act. Their endocrine system in order to energize the organism, will produce or over-produce through the activation of the sympathico-medullo-pituitary-adrenal system those hormones which enable them to attack and wipe out a threat or an obstacle. Or, in our civilized life, to adjust to it. If the problem of adjustment (FIGHT) conflicts with an individual's instinct of survival, his moral, ethical, religious standards, then he WILL FLEE.

Escape and Withdrawal

Group 3 deals with a life situation by pretend-

ing *there is no problem*. Or, where evasion is not possible, by procrastinating in the making of a decision. Such a person may say, "Well . . . one day I shall resolve this or that." People of that group are capable of resolving their problems partially in a realistic manner, but the greater part of their gratification is obtained from fantasy living.

Group 4 has affectionately little contact with reality. People of that group may function professionally, or in their work, well—for a while; but they will have difficulty with living because for the most part they seem to have little belief in themselves, and can therefore not bring themselves into a positive relation to the society in which they live. A further consequence is that they lack direction, and cannot build a clear meaningful goal for themselves, except a basically destructive one. The greatest difficulty this type has throughout life is to control deep-seated hostility and self-destructive drives.

The Heart Patient

In a paper which I read just two years ago at the Convention of the American Psychological Association, dealing with the "Psychological Aspects of the Dying Patient" I confronted the two killers of our time—Heart Disease, and Cancer,—and I tried to examine whether there is a relationship between these diseases and personalities. According to my observation, there is little doubt that the person suffering or dying from a heart disease, belongs primarily in *Group 1*. His reaction towards life situations stimulates primarily the sympathetic nervous system.

The Cancer Patient

Patients with cancer, I believe, die from a negative state of stress—so to say. They die when they are overcome by a state of futility and hopelessness. We have lately gained scientific proof that the heretofore belief, that man dies when his heart gives out, in a last effort during a systole,—cannot be maintained any longer. Man can die, and does die, by giving up.

Recent experiments by Carl Richter on rats show that his special breed of aggressive Australian rats, could swim 60 to 80 hours, but when they were confronted with a hopeless situation, would die within minutes. Contrary to this researcher's expectations, death seemed to have occurred as the result of an over-stimulation of the *parasympathetic* system rather than the *sympathico-adrenal* system. He came to the conclusion that sudden death has been described in man and many animals apparently as a result of hopelessness, which seemed

to involve over-activity of the parasympathetic system.

Hopelessness as Cause of Death

Recent studies of the effects of imprisonment on American soldiers during World War II show that approximately 94,000 United States soldiers were taken prisoners of war in Europe. Most of them were imprisoned for about 10 months; less than one per cent died. In contrast, in the Pacific Theater, approximately 25,000 Americans became prisoners, and remained in prison for over three years. They were exposed to threats, abuse, and humiliation and about one third of them died. During the Korean War, about 6,000 soldiers were captured by the North Koreans and here again, about one third died. The cause of death in many instances was not very clear, and the reference was made to "give-up-itis" as the cause of death. States of demoralization, despair, humiliation, and a sense of futility caused apathetic listless states, with feelings of not caring, of refusing food or drink, of staring into space, and of a gradual decline of vitality ending in death.

Summary

Health is a state of balanced functioning, an inner drive of adaptation to the stresses of life. As long as an individual is emotionally and physically able to adjust to stress he can maintain a state of balance and will remain whole—that is, healthy. If a situation proves to be stronger than the individual, then something in the personality must break. This can be a physical or mental break. It will depend on the individual's ability to find his way out of the dilemma, by either breaking the situation, or by a process of readjustment—which means not simple compromise but a positive acceptance of a life situation or situations—without inner rebellion, resentment, or unconscious hostility and thereby allow a system to regain a state of balanced functioning. It is safe to say that the individual who is capable of accepting responsibility and can relate to his environment, will be able to fulfill himself creatively, and because these people are capable of building mature goals for themselves, the chances are that they will remain wholesome.

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Magnesium Depletion in Man And Related Symptoms

Study of 12 patients who suddenly developed psychiatric and neuromuscular symptoms revealed evidence suggesting a relationship between these symptoms and a depletion of the total body magnesium. The serum magnesium concentrations were significantly depressed in nine, and the serum calcium values were low in all 12.

Clinical improvement followed the administration of magnesium by the parenteral route or in the diet, and sometimes the improvement was dramatic. There were several instances in which abnormal electroencephalograms and electrocardiograms improved following magnesium therapy. Administering calcium alone did not correct the neuromuscular disorder in two patients, and it may actually have intensified the symptoms. Treatment with magnesium usually resulted in a markedly positive magnesium balance, and it sometimes produced significant increases in the serum calcium concentration and the renal excretion of calcium.

The following clinical features in the above patients were probably concerned in the etiology of the presumed magnesium depletion: severe malnutrition and usually some source of fluid and electrolyte loss, such as vomiting or diarrhea. Excessive renal excretion of magnesium in one patient was probably related to a state of potassium depletion.

There is considerable suggestive evidence that an intracellular depletion of magnesium is of primary significance in the production of symptoms.—(*Abstract*): Randall, Russell, E., Jr.; Rossmesl, Elsie C.; and Bleifer, Kenneth H., Boston: *Ann. Internal. Med.*, 50:257-287, February, 1959.

"Redigitalization Phenomenon"

It has been noted that patients laden with edema fluid and digitalized would exhibit manifestations of digitalis intoxication with mobilization of fluid with mercurial diuretics. It was first thought that this was due to utilization of digitalis contained in the edema fluid, but doubt was cast on this explanation when it was shown that the administration of the same amount of digitalis mobilized with diuresis did not cause toxic manifestations. A second and more plausible view, is that diuresis, by producing a potassium loss, reduces the heart's threshold to the toxic properties of digitalis. It has been shown that (1) administration of potassium salts during this period leads to reversal of toxicity, and (2) its administration prior to diuresis prevents intoxication. — Henry Holderman, Oakland, Calif.: *Missouri Med.*, 56:272, March, 1959.

Early Management of the Patient With Multiple Injuries*

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THE patient with serious multiple injury offers a unique challenge to the medical profession. He presents a disease which does not occur frequently in the practice of most physicians and hence finds many of us not ready and not well prepared for its proper management. When the seriously injured man appears, however, he must have immediate and well conceived treatment without delay. Improper early care can easily lead to unnecessary loss of life or prolonged disability.

In this age of hurricanes, typhoons, and tornadoes; of international tensions and nuclear weapons; of automobiles and excessive speed, none of us can afford to be complacent about the management of injuries. In 1957, according to statistics compiled by the National Safety Council,¹ 9,600,000 people were injured, and 95,000 died accidental deaths in the United States. In the event of a nuclear blast in a metropolitan area the wounded might be numbered in the hundreds of thousands in addition to those killed outright.

These facts make it urgent that all concerned with patient care, including physicians, residents, medical students, nurses, and orderlies, be thoroughly familiar with principles of management of the injured patient. When serious injury occurs, whether it be in a single patient or in hundreds, the procedures necessary to save the patient's life must be second nature to the man who must deal with the problem. He must be able to act promptly and surely, and he must know that whatever emergency equipment might be necessary is readily available to him and clearly identified.

Coordination of Management

The management of the patient with multiple injuries must be a cooperative endeavor. The man who assumes initial or overall responsibility for the patient (usually a general surgeon or a "generalist") must work closely with various specialists who may be required to attend the patient. He must help decide the priority for treatment of the various injuries and must repeatedly reassess the general condition of the patient. In the Cleveland Metropolitan General Hospital, a special team has been established to carry out this function in cooperation with members of the specialty services.

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Detection of Inconspicuous Injury

Of prime importance is the recognition of the patient with seemingly minor trauma who may have potentially fatal underlying injury with slowly appearing manifestations. Although a well developed tension pneumothorax is easily recognized, the patient who has sustained a blow to his chest wall, with or without fracture of a rib, may seem deceptively well when initially seen. Five or six hours later, however, he may develop serious respiratory embarrassment due to a small tear in his visceral pleura. The patient with a bruise over his left lower chest wall, who may be otherwise asymptomatic and present no physical findings of apparent significance, may go into profound shock hours, days, or weeks later, when the small laceration in his spleen ruptures through the capsule. Head injuries may also present few symptoms and no significant finding early following injury, only to develop increasing intracranial pressure and consequent brain damage much later.

All these lesions may masquerade as trivial injuries when the patient is first seen, and he may be dismissed from the hospital only to suffer avoidable complication and catastrophe later. Or he may be admitted to a special service where attention may be so focused on his more obvious injury that a less apparent but potentially dangerous injury is recognized only when the patient goes into shock. This danger is something for which both the specialist caring for the patient and the general surgeon following him must be constantly on the alert.

Obvious Injury

The patient with obvious serious injury presents a somewhat different problem. A number of dif-

ferent organ systems might be damaged, and each of these may threaten life. It is essential that the physician responsible for the management of the patient have in mind a well conceived and orderly plan of management.

Priority of Treatment

Priority of treatment for the individual patient must be established. This priority should include:

1. Rapid assessment of the patient's general condition.
2. Arrest of any brisk external hemorrhage.
3. Maintenance or restoration of adequate ventilation.
4. Measures to prevent or correct shock.
5. Thorough but expeditious examination.
6. Operative intervention, as part of resuscitation if necessary.

We shall examine these priorities a bit more closely.

1. Initial Examination

In the initial rapid appraisal of the patient's status we should attempt to detect primarily those disorders of his normal physiology which are incompatible with survival for more than a brief period. The presence or absence of significant external bleeding, respiratory distress, and shock should be determined. These may require correction before time may be taken for a detailed examination.

2. External Hemorrhage

In the event of severe external hemorrhage, control by direct pressure is usually the most effective and least damaging method. Direct clamping with hemostats is satisfactory for smaller vessels, but care should be taken if possible to avoid further injury to major vessels and other important structures. Proximal tourniquets may be required for short periods. This will impose additional hazards, however, and may actually increase bleeding if improperly applied. Direct pressure on the area involved is much to be preferred. Once applied, an arterial tourniquet should not be released until facilities are available for definitive control of the bleeding.

3. Respiratory Embarrassment

Respiratory embarrassment is a frequent complication of trauma and must be corrected immediately.

Airway: First and foremost we must be sure that the patient's airway is not obstructed. In unconscious patients, the tongue may fall back to occlude the pharynx and cause asphyxiation. Drawing the tongue forward, adjusting the position of

the patient, or inserting an oral or nasopharyngeal airway will overcome this problem. In the event of injury to the face or neck, edema and hemorrhage may cause obstruction of the upper trachea or pharynx. Partial obstruction of this sort may progress very suddenly indeed to complete obstruction, and tracheostomy must be performed before this can occur.

Bronchial secretions may cause significant obstruction to the airway, especially in wounds of the chest and head injury. With crushing injuries and penetrating wounds of the chest, bronchial secretions may be mixed with blood compounding the difficulty. It is essential that the tracheo-bronchial tree be cleared of secretions by effective and repeated aspiration when they are present. Tracheostomy may facilitate aspiration and should be done without hesitation when needed.

Ventilation: Inadequate respiratory exchange may be an important cause of hypoxia. Shallow respirations are frequently associated with head injury or follow the administration of excessive amounts of morphine. A flail chest wall associated with multiple rib fractures will also prevent adequate exchange. In such instances it may be necessary to assist respirations by means of positive pressure oxygen insufflation with a bag through a properly fitting anesthesia mask or an endotracheal tube. Here again a tracheostomy may be of considerable benefit not only for aspiration of secretions but to reduce the amount of dead space present in the air passages. In the absence of special equipment, artificial respiration should be employed. The most effective method is mouth-to-mouth insufflation with the nares closed and the neck extended.

Pain: Intercostal pain associated with rib fractures may cause significant limitation of respiratory motion. Procaine block of intercostal nerves will afford dramatic improvement in such instances. The use of morphine, of course, should be restricted in the presence of respiratory difficulty.

Pneumothorax: Acute embarrassment of respirations may be caused by the presence of a pneumothorax, either open or closed. An open pneumothorax, or "sucking wound" of the chest, in addition to allowing total collapse of the lung on the affected side, interferes markedly with ventilation of the opposite lung. The open wound must be promptly sealed by means of a large vaseline gauze pressure dressing and the pneumothorax aspirated.

Closed pneumothorax may be caused by blunt trauma with rupture of normal lung or of an emphysematous bleb, by laceration of the lung on a projecting fragment of broken rib, or by a

penetrating wound with laceration of the lung in which the external wound is effectively sealed. Because of the valve-like action of the lacerated lung, tension often develops within the pleural space. This leads to collapse of the ipsilateral lung, shift of the mediastinum to the opposite side, and impairment of ventilation of the opposite lung.

Tension must be relieved by aspiration with provision made for escape of any further accumulation of intrapleural air. An intercostal catheter or a large-bore needle attached to water seal is most effective. In emergency, a flutter-valve made by attaching a moist finger cot with a slit in its distal end to a large bore needle can be very useful. Inserted into an intercostal space this will allow escape of air and may be easily used while the patient is being transported.

4. Shock

Shock may be defined broadly as "the clinical manifestations of an inadequate volume of circulating blood accompanied by physiologic adjustments of the organism to a progressive discrepancy between the capacity of the arterial tree and the volume of blood available to fill it." (Simeone)²

Blood Loss: In the severely injured patient, shock is most commonly associated with acute blood loss. While the source of bleeding may be obvious, it is not always so. Vigorous external hemorrhage may have subsided to a slow ooze by the time the patient presents himself. Significant internal bleeding may occur into the pleura or peritoneum. The amount of blood loss into soft-tissues, especially in association with major fractures, may assume massive proportions. Such blood loss must be compensated by immediate replacement and prompt control of the source of hemorrhage. Replacement, of course, should consist of whole blood whenever available, although plasma, plasma expanders, or saline may be used in limited quantities if whole blood cannot be readily obtained. Intravenous infusions must be used with some caution in patients with severe pulmonary damage, fat embolism, head injury, or in elderly or debilitated people.

Cardiac Tamponade: A frequently unrecognized and rapidly fatal cause of shock is cardiac tamponade. Yet, with proper management, the salvage rate for people with wounds of the heart is surprisingly good. Indications of the presence of cardiac tamponade include a lowered arterial blood pressure which is refractory to transfusion, signs of increased venous pressure, a paradoxical pulse, distant heart sounds, and enlargement of the area of cardiac dullness. Aspiration of the pericardium by inserting an 18 gauge needle just

to the left of the xiphoid and angling it acutely upward until the beating ventricle is felt, may establish the diagnosis. Emergency pericardiocentesis and immediate thoractomy can be lifesaving and must be undertaken without delay.

Crush: Shock sometimes may appear in patients without significant loss of blood when circulation is occluded by a crushing object and then released with rescue. These patients will tend to be hypovolemic with a normal red cell volume. If the hematocrit is greatly elevated, the prognosis is quite poor. In general the treatment is somewhat similar to that in severe burns with early use of intravenous solutions and close observation of the urinary output.

Pain: The physiologic picture in severely traumatized patients may be profoundly altered by their apprehension and pain. Pain, however, is usually not so severe as one might expect from the magnitude of the injury if the patient is not further traumatized by rough handling. The management of pain, therefore, should be directed largely toward immobilization of the traumatized part and extreme gentleness in moving the patient. The use of morphine should be held to an essential minimum because of its depressant effect. It is also poorly absorbed in the presence of circulatory depression unless administered intravenously. For this reason repeated subcutaneous injections of narcotics must be avoided.

5. Examination of the Patient

The problems with which we have dealt thus far must be treated after only superficial appraisal of the patient. It is important, however, as soon as the patient's urgent physiologic needs have been met, to perform a thorough, although expeditious and gentle, examination. In addition to the usual physical examination including the chest, abdomen, neurological status, and area of obvious trauma, there are a number of points to observe which may easily be overlooked.

(a) The surface of the body should be meticulously inspected for penetrating wounds of which the patient may be unaware. Wounds of the back and buttocks are commonly missed, yet they may well be associated with serious abdominal or thoracic injury, as may wounds of the thighs and shoulders.

(b) The presence or absence of all major arterial pulses must be ascertained.

(c) Careful examination of sensation and motor power in an injured extremity should be carried out.

(d) Rectal examination is essential in all seriously injured patients, not only to ascertain the presence of rectal injury but to note the pres-

ence of blood. Blood in the rectum may signify injury anywhere in the gastrointestinal tract.

(e) All patients with fractures of the pelvis must be assumed to have serious bladder or urethral tears which must be promptly investigated. Bleeding from the urethra is diagnostic. Immediate urinalysis is essential in all injured patients, especially to note the presence or absence of red blood cells in the urine. The presence of significant numbers of red cells in the urine is diagnostic of injury somewhere in the genitourinary tract. Failure to feel the prostate gland on rectal examination points to severance of the membranous urethra.

(f) In equivocal situations, x-ray findings may be of considerable help. The presence of free air beneath the diaphragm on an upright film is *prima facie* evidence for rupture of the stomach or intestine. Elevation of the left leaf of the diaphragm, increased density in the left upper quadrant, indentation and serration of the greater curvature of the stomach, or depression of the splenic flexure of the colon may suggest rupture of the spleen. Retroperitoneal gas may indicate the presence of rupture of an extraperitoneal portion of the duodenum or colon. Emergency cystography and intravenous pyelography may be indicated to help detect injury to the urinary tract. Early abdominal roentgenograms may be especially helpful to compare with later films, which may show change in fluid or gas patterns or in visceral contours.

(g) Most important in the examination of patients with major injury is to avoid the pitfall of concentrating on an obvious injury to the extent that less apparent but serious injuries are overlooked.

Surgical Intervention

Last but not least on our priority list for the patient with multiple injuries is consideration of surgery. There are many instances where formal operative procedures must be considered an integral part of resuscitation. To wait for the patient with continued bleeding from his ruptured spleen or torn internal mammary artery to "stabilize," is to invite disaster. Ideally the optimum time for exploration is when the patient's blood pressure begins to rise following the resuscitative measures outlined above. With severe bleeding, however, this may not occur, and every minute of delay will prejudice the patient's opportunity to recover. If one waits until a normal blood pressure has been obtained, vigorous hemorrhage may begin again. The second episode of shock so engendered may be much more difficult to combat than the first.

An equally important part of resuscitation may be surgery to prevent infection or to curb infection

once it has become established. Extensive extravasation of urine from a ruptured bladder, retroperitoneal dissection from a lacerated duodenum, or contamination of the peritoneum from a perforated colon will lead to continued invasive infection. Resuscitation may be impossible until these factors have been brought under control.

When intra-abdominal injury is seriously suspected, early operation should be undertaken. The occasional negative exploration is more than justified in order to avoid the serious or fatal complications of delay.

Summary

Priority of treatment for the individual patient with multiple injuries should be established. The importance of such a priority should be stressed in hospital teaching programs. Such a priority should include:

1. Rapid assessment of the patient's condition.
2. Arrest of brisk external hemorrhage, usually by manual pressure.
3. Maintenance or restoration of adequate ventilation, including adjustment of airway, aspiration of secretions, administration of oxygen, tracheostomy when indicated, and treatment of pneumothorax.
4. Measures to prevent or correct shock.
5. Thorough but expeditious examination.
6. Operative intervention, as part of resuscitation if necessary.

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Hypophysectomy for Palliation Of Breast Cancer

In a series of 19 patients who had hypophysectomy for palliation of cancer of the breast, all had striking relief of pain. Objective evidence of remission of disease was observed in 10 patients.

The survival time after operation averaged 19.8 months for patients who had remission and 2.1 months for patients who did not.

Results were better in patients who had had cancer for a long time before operation than in those who had had the disease a relatively short time. Also it was noted that results were better in patients who had had preoperative response to endocrine therapy than in those who had not. Hence these factors may be considered in selection of patients for hypophysectomy.—Norman L. Cobb, M.D., San Diego, Calif., and William B. Scoville, M.D., Hartford, Conn.: *California Med.*, 90:261, April, 1959.

Stomal Influence on Duodenal Stump Leakage

EDWARD L. DOERMANN, M. D.

THE prime danger inherent in the Billroth II type gastrectomy is the "blown out" or leaking duodenal stump. This complication occurs in up to 3.7 per cent of resections¹ despite the multitude of ancillary agents now available to the surgeon in the form of fluids, antibiotics, improved suture materials, etc.

Causes

Most patients subjected to this operative procedure suffer from peptic ulcer and are resected either for perforation, hemorrhage, obstruction or intractability. In most instances their nutrition and healing capacities are essentially normal or can be made so prior to surgery. In these people, then, the blown stump usually cannot be charged to inadequate healing capabilities but must be considered to be due to technical flaws in the closure of the duodenum.

No one, I am sure, would argue the necessity for meticulous and painstaking closure of the duodenum. To allow even a vestige of mucosa to interfere with serosal apposition is inviting a leakage, and usually one is not disappointed. Yet occasionally one sees this complication occur in patients with benign gastric ulcer with perfectly normal duodenal tissues adequately and carefully closed according to all the precepts of good intestinal surgery. Some other factor, then, must be exerting influence on duodenal healing, and one does not need to search farther than the gastroenteric anastomosis. In fact, the farther from the duodenal closure one has to search to find this anastomosis the higher will be the incidence of duodenal leakage.

This observation has been made by others. Avola and Ellis² analyzed 13 cases of duodenal leakage after Billroth II gastrectomy, four of which were due to stomal or afferent loop obstruction. Three of the four had an antecolic anastomosis. Stammers³ in 1954 analyzed 16 cases and found that of these 15 had an antecolic anastomosis.

The longer afferent loop required in doing an antecolic anastomosis predisposes to kinking and obstruction of the loop with resultant increased intraduodenal pressure which the suture line cannot tolerate. As stated by Avola and Ellis, "Obstruction has long been considered one of the most important factors in the pathogenesis of

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duodenal stump dehiscence. As a contributory cause of duodenal stump leakage it is most commonly seen occurring in the afferent loop due to torsion or kinking of the loop at the site of a malfunctioning stoma."²

Antecolic vs. Retrocolic

Recognition of the influences of gravity, anatomy, and peristalsis on stomal function are convincing evidence that the best anastomosis, both from the standpoint of stomal function and its influence on intraduodenal pressure and ultimately on the security of the duodenal closure, is a gastrojejunostomy performed with the proximal loop to the lesser curvature of the gastric remnant and as close to the ligament of Treitz as is anatomically possible. This, then, must be a retrocolic anastomosis since of necessity an antecolic anastomosis requires a longer jejunal loop. If properly performed, the stomach when brought through the avascular area of the transverse mesocolon will lie in juxtaposition to the ligament of Treitz, and the gastrojejunostomy can be performed with ease at this point with a very short blind loop and therefore little danger of kinking. Granted, in those patients with a short, thick transverse mesocolon an antecolic anastomosis is the procedure of choice.

The other potential cause of increased afferent loop pressure is the dependent position of the proximal loop in an antiperistaltic anastomosis. If the proximal loop is sutured to the greater curvature side of the stomach, two situations are created: (1) a longer afferent loop is again created; (2) because of the dependent position of the loop the influences of gravity and peristalsis, working in opposing directions, result in increased intraduodenal pressures.

Influence of Gravity

Under the influence of gravity food will dump first into the dependent loop of small bowel—in

this instance the blind loop of duodenum which can ill afford increased intraluminal pressure. The food then must be pushed back out, up and over the hump into the distal loop, gravity and peristalsis now acting as opposing forces. Schmidt and Melick⁴ in 1945 performed upper gastrointestinal barium studies on post-gastrectomized patients, demonstrating that the gastric remnant emptied rapidly into the dependent loop of the small bowel. This increased pressure alone may be enough to jeopardize the duodenal suture line.

The duodenum receives daily a large amount of fluid material in the form of bile, pancreatic juice, and mucosal secretion. The amount has been stated as being approximately 1000 to 1500 cc. This amount of fluid alone, if its progress is impeded, may increase intraduodenal pressure tremendously. Add to this food or fluids ingested and dumping first into the blind loop instead of the distal loop, and at once a dangerous situation is created. Dragstedt⁵ in 1929 pointed out that the duodenum is more susceptible to distention than any other part of the gastrointestinal tract. The use of the short proximal loop to prevent duodenal stasis and distention was emphasized by Schmidt in 1943,⁶ and many others. If the proximal portion of the small bowel is placed at the lesser curvature when making the anastomosis an ideal emptying situation is created, since obviously gravity and peristalsis, working in the same direction, move ingested material away from the duodenum and into the dependent distal loop.

Other Considerations

Aside from these important considerations, there are other reasons of no less importance for making the anastomosis as close to the duodenum as possible. Introducing the food substances into the gut at a distance from the duodenal "mixing chamber" reduces the efficiency of digestion. It therefore behooves the surgeon to anastomose as close to the source of the digestive enzymes as possible. In addition, Wangenstein's studies have indicated that the incidence of marginal ulcer increases the farther the anastomosis is placed from the duodenum. The Billroth I operation, in which gastroduodenal continuity is re-established, would answer these problems, but recent studies indicate that the incidence of recurrent ulcer is prohibitive.

Since 1885, when von Hacker first introduced the retrocolic anastomosis, the history of gastric surgery has been one of continuing debate between those who advocate retrocolic and those who advocate antecolic anastomosis. They do, however, agree on one point—the ruptured duodenal stump is one of the most serious complications of either

technique. The recognition of the principles previously described can reduce the incidence of this complication and the afferent loop syndrome as well.

Summary

More than the actual technique used in closing the duodenal stump must be recognized as influencing healing of that critical suture line. The position of the gastroenteric stoma in relation to the ligament of Treitz and the direction of peristalsis both have a definite influence on intraduodenal pressure and ultimately on the integrity of the duodenal closure. Using a retrocolic anastomosis with a very short proximal loop placed to the lesser curvature of the gastric remnant avoids several situations which have been shown to increase the incidence of duodenal rupture.

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Significance and Treatment of Prostatic Nodules

To initiate or deny irreversible definitive therapy solely because of impressions derived from palpation of the prostate is fraught with danger. Not all nodules of so-called third-degree induration are malignant, and some carcinomas are only slightly indurated. Histologic confirmation of the clinical diagnosis is imperative if total prostatectomy is to be employed judiciously.

Fresh frozen-section biopsy can be reliable, and perineal exposure of the gland offers the best opportunity for adequate appraisal of the prostate. If benign lesions are not encountered occasionally, it is proof that more nodules should be investigated.

Total prostatectomy still seems to be the treatment of choice in properly selected cases but there must be strict adherence to rigid criteria in the choice of candidates or the operation will be abused as it undoubtedly has been in the past.

The combination of proper selection of patients, timely investigation of suspicious nodules, histologic confirmation of diagnosis, and meticulous attention to operative details should prevent therapeutic injustices and enhance the value of total prostatectomy.—Ormond S. Culp, M.D., Rochester, Minn.: *J. Michigan M. Soc.*, 58:585, 1959.

Report on a Study of Amebiasis in the Cleveland Area

WALTER L. GEORGE, M. D., and JOHN MESSINA, M. D.

THE frequency with which the diagnosis of amebiasis is made in the temperate zone has not kept pace with facts revealed by carefully conducted surveys over the past 10 to 20 years. Most of the investigations quote an incidence of 10 to 20 per cent in the general population; yet the diagnosis of a case of amebiasis in the northern United States, exclusive of some centers of study, is still a relative oddity. Why?

It has taken and is taking years to discredit the illusion that dysentery—that is, liquid, bloody stools with severe abdominal symptoms, fever, etc.—is a necessary sequel of infection of the human colon with *Endamoeba histolytica*. Experience has shown repeatedly that this is a misconception. In general, the toxic picture of acute dysentery and its complications, hepatitis, liver and brain abscesses, is more common in the subtropical and tropical zones.

Materials and Methods

In the past nine years we have carefully examined approximately 2,000 patients in whom the diagnosis of amebiasis was suspected clinically. Of this group, we were able to establish this diagnosis in 175 cases.

Our study was based primarily on purgative specimens of stool. A saline cathartic (a combination of sodium phosphate and sodium biphosphate) was administered on retiring; a sample of the second stool passage was collected the following morning. A small portion of the stool, the size of a pea, was suspended in tap water and centrifuged. After all the sediment had been concentrated, the supernatant water was poured off and the sediment resuspended in 40 per cent zinc sulfate solution. This was again centrifuged and, upon completion of this step, enough 40 per cent zinc sulfate solution was added to the centrifuged specimen to fill the tube to the point of overflowing. At this point the cysts were concentrated on the surface and were removed by a cover slip merely by touching the latter to the surface of the zinc sulfate. The cover slip was then placed on a slide that had a drop of Lugol's solution on it. The iodine stained the cysts for easier identification. Once the cysts were found, iron hematoxylin stained smears were prepared in order to demonstrate the black staining "sausage-shaped" chromatoidal bodies of *E. histolytica* as compared to the splintered "tooth-pick" like chromatoidal bodies of the cysts of *Endamoeba coli*.

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Whenever the patient presented a frankly dysenteric "currant jelly" stool, the purgative was dispensed with and an intensive search was made for the motile trophozoite by immediate observation of the stool microscopically, using a saline drop suspension. The important diagnostic clues here were the rapid, purposeful movement of the trophozoites of *E. histolytica* and the observation that these trophozoites frequently ingested red blood cells.

On those patients in whom the diagnosis of amebiasis was suspected but in whom the stool studies were negative or in whom ulceration of the bowel was suspected, sigmoidoscopy was performed. In 12 of these patients, typical pinpoint amebic lesions with grayish-white exudate and normal intervening bowel were seen. At this point, material was obtained from the suspected areas for a direct fecal film study.

Serologic Testing

Since the work of Izar in 1914, it has been known that *E. histolytica* had antigenic properties that could be demonstrated in the patient's serum. The test was developed by Craig to a point where it appeared feasible to use it as a screening test. However, subsequent investigators failed to establish any particular antigen as sufficiently sensitive to denote with consistency any cases of amebic infection, except those involving extra-colonic tissues (liver, etc.).

For the past five years we have been using an antigen which we have developed in our laboratory, utilizing both the large and the small forms of the trophozoites of *E. histolytica*. Thus far, this antigen has given approximately 75 to 80 per cent positive correlation with stools positive for *E. histolytica*. A few false positives have been noted in patients with Hodgkin's disease and rheu-

matoid arthritis. There have been a few positive serologic reports in patients in whom we have not been able to establish the diagnosis of amebiasis, Hodgkin's disease or rheumatoid arthritis. These were usually patients who cooperated poorly in returning for additional stool studies. The oc-

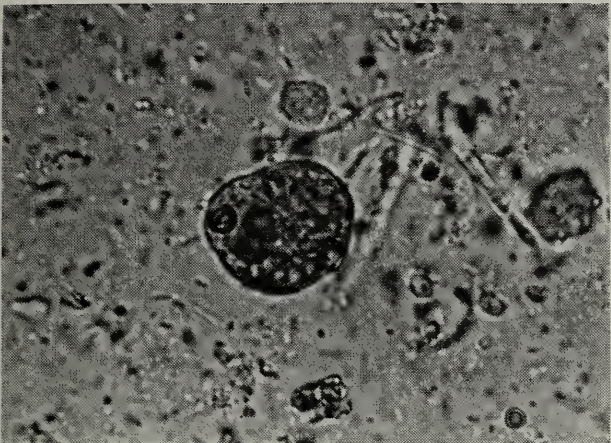


FIG. 1. A red blood cell is seen penetrating the outer cell wall of *E. histolytica*.

casional appearance of a positive serologic report in a patient with only rheumatoid arthritis or Hodgkin's disease is under investigation currently.

Clinical Findings

We found no typical features of amebiasis in our survey. In some of the patients, bowel habits were normal. Approximately 65 per cent of our patients gave a history of diarrhea alternating with constipation. Approximately 80 per cent of the patients in this series complained of vague abdominal discomfort, flatulence and recurrent pains in the right lower quadrant. A history of negative, intensive gastrointestinal studies was not unusual. A few of the patients had undergone fruitless abdominal surgery. An unexpected finding was that 60 per cent of the patients who had a positive diagnosis for amebiasis also gave a history of severe recurrent occipital headaches. The significance of this finding is not known.

Therapy

A number of amebicides are available on the drug market today. However, in order to better evaluate our results, we restricted ourselves to the following therapeutic regimes:

1. Treatment of mild amebiasis (those cases in whom we describe the so-called carrier state). These individuals demonstrated *Endamoeba histolytica* in their stools, but their symptoms were those of vague discomfort and their stools were usually formed or constipated. Clinically, this group showed no evidence of extraintestinal amebiasis.

These patients were given Diodoquin® (Searle)

10 grains three times daily for 20 days. Following this, their stools were checked again for the presence of *E. histolytica*. If the disease was still present, a second course of therapy was prescribed.

2. Treatment of moderate amebiasis (those cases in whom fulminating diarrhea and bloody stools had appeared). These patients were given a wide spectrum antibiotic such as Achromycin® (Lederle). The dose was usually one gram daily in divided doses for four days. This was then followed with a course of Milibis® with Aralen® (Winthrop), consisting of two tablets three times daily for seven days (one-half this dose if the patient weighed less than 80 pounds). Each tablet contained Milibis 0.25 gram (of which 15 per cent is arsenic and 42 per cent is bismuth) and 75 milligrams Aralen Phosphate (7-chloro-4[4-diethylamino-1 methyl-butylamino]quinoline).

In rare cases, where the liver was severely involved, the patient was hospitalized for a five-day course of emetine hydrochloride one grain

CASE FINDINGS
IN CLEVELAND AREA
(POSITIVE STOOL EXAMINATION)

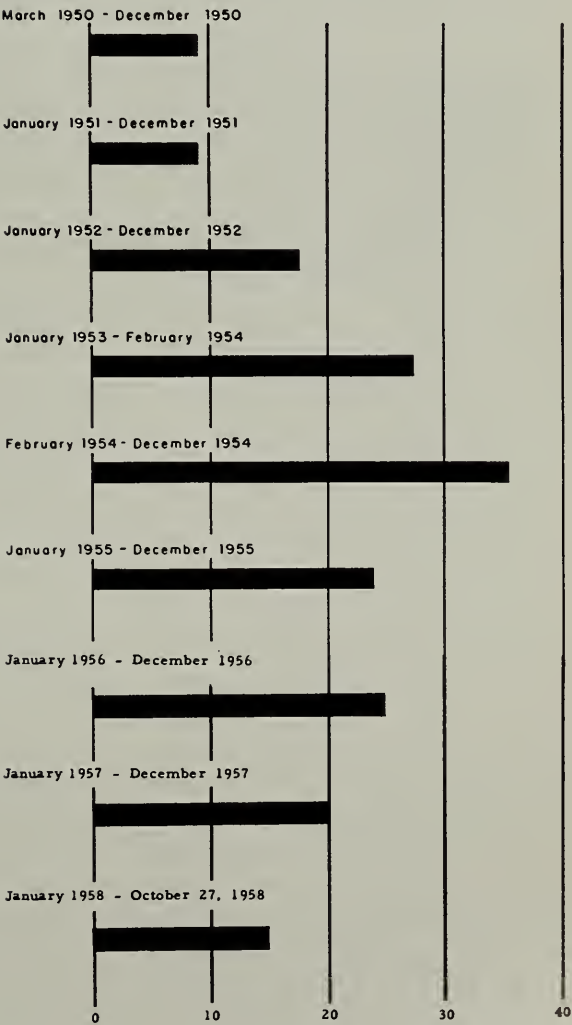


FIGURE 2

intramuscularly, in addition to the treatment outlined previously. Hospitalization with close electrocardiographic follow-up was made necessary by the known toxic effect of emetine upon heart musculature.

Recurrence Rate

In our series of over 175 cases, 50 per cent of the patients experienced at least one recurrence necessitating a second course of treatment. Ten per cent of our patients required a fourth course in order to eradicate amebiasis clinically and by laboratory studies.

Summary

Amebiasis does occur in the temperature zone with some frequency. In the Cleveland area, we have discovered over 175 cases of amebiasis, all identified in the laboratory and treated medically. A similar rate of incidence probably occurs in other areas.

Conclusion

With more intensive training of laboratory technicians and the development of more accurate procedures for serologic testing, amebiasis will be detected and treated much more frequently and much more successfully by the practicing physician.

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A New Anti-Tumor Agent Streptovitacin A

The tumors of streptovitacin-treated animals showed marked disruption of normal growth with areas of liquefaction and necrosis when the authors evaluated the drug under a variety of conditions in a spectrum of mouse and rat tumors and in two dogs with spontaneous neoplasms. Streptovitacin A is a new crystalline antitumor principle that was isolated from a fermentation product of a *Streptomyces*.

Relatively minute quantities of the drug produced significant inhibition of all of the mouse and rat tumors studied: Sarcoma 180, RC carcinoma, Ehrlich ascites, Leukemias L4946 and L1210, Walker carcinosarcoma, Jensen sarcoma, and Murphy-Sturm lymphosarcoma. Doses of 0.4 to 0.6 mg/kg/day given to mice prolonged life or reduced the size of the tumor by 45 to 60 per cent. The rat tumors responded similarly. Streptovitacin induced temporary remissions in two dogs with spontaneous neoplasms.—(Abstract): Field, John B.; Mireles, Annie; Dolendo, Edward C., et al., Los Angeles: *Cancer Research, Proc. Am. Assoc.*, 3:19, March, 1959.

Mouth-to-Mouth Resuscitation Has Many Advantages

"And he (Elisha) went up, and lay upon the child, and put his mouth upon his mouth, and his eyes upon his eyes, and his hands upon his hands: and he stretched himself upon the child; and the flesh of the child waxed warm." II KINGS 4:34.

A recent revival of the Bible method of helping asphyxiated patients to breathe again is being used by the Army Medical Service, according to the office of the Surgeon General, Technical Liaison office, Washington, D. C.

Called "Mouth-to-Mouth" resuscitation and believed to be "the best system available," the method is now being taught at Brooke Army Medical Center, Fort Sam Houston, Texas, to all personnel at the Army Medical Service School, including assigned instructors and administrative personnel, demonstration troops, and students, whether officers or enlisted men or women.

The process is new in recognition only, for, apart from the story of Elisha, medical history recorded successful resuscitation by mouth-to-mouth breathing more than 200 years ago. Studies conducted during the past few years have proved the superiority of this procedure in comparison with other methods of artificial respiration in common use.

In its simplest form, the operator removes any mucus or foreign matter from the victim's throat and mouth, with his fingers. He then takes a firm hold on the patient's lower jaw, tilts the head back by pulling on the jaw, pinches the patient's nostrils shut, and after taking a breath places his mouth over the patient's mouth and exhales until he sees the chest of the patient lift. The operator then takes his next breath while listening for the patient's exhalation. The operator breathes about 12 times a minute for adults, and about 20 times a minute for children.

Advantages of the process are many. Mouth-to-mouth resuscitation forces more air into the patient's lungs; it is more easily controlled by the operator; the operator can continue for a long period of time with no ill effects; it is effective with any asphyxiated patient; no equipment is needed for maximum results, but if equipment is available, it allows greater freedom of motion for attendants.

Contrary to popular belief, exhaled air is not entirely carbon dioxide, but contains enough oxygen to revive the patient with no harmful effects from carbon dioxide. In addition, laboratory tests conducted under the auspices of the U. S. Army Medical Research and Development Command, have proved that the volume of air displaced by this method is several times greater than that by any other system of artificial respiration.

Cancer of Larynx

EZATOLLAH FOROUGH, M. D., and RAYMOND S. ROSEDALE, M. D.

SINCE the earliest and most nearly constant clinical manifestation of cancer of the larynx is hoarseness, it has been known as long as the human being has been able to speak. Hippocrates wrote of laryngeal cancer in 400 B. C. and Virchow described its histology in 1858. Sand performed the first laryngofissure for cancer in 1868.

The maximum incidence of cancer of the larynx has been noted in the sixth decade; it is uncommon before the age of 25, although it has been reported in a child three years old. It is 13 times more common in men than in women; however postcricoid carcinoma of larynx is more common in females. A history of alcoholism, as well as the use of tobacco, has been found in a rather high percentage of cases. Syphilitic leukoplakia of the larynx with potential malignant transformation has been regarded by some as an important etiologic factor.

Cancer of the larynx has been divided into two types on the basis of location: intrinsic and extrinsic growths. The intrinsic group constitutes about 70 per cent of cases and usually arises on the anterior two-thirds of the vocal cords, on the ventricular folds, in the ventricular pouch or on the inner aspect of interarytenoid region. The extrinsic tumors are usually located on the epiglottis, epiglottic folds, the arytenoids, pyriform sinuses or the posterior portion of the laryngeal wall which constitutes the anterior wall of the pharynx.

The histologic picture of cancer of the larynx depends upon the region from which the malignant growth originates. About 98 per cent of the cases are squamous cell carcinoma with varying degrees of differentiation; approximately 95 per cent of this type originate from the vocal cords. The remaining 2 per cent have been reported as basal cell carcinoma, adenocarcinoma, cystic adenocarcinoma, endothelioma and different varieties of sarcoma.

The mortality rate of cancer of the larynx, unless treated, is 100 per cent within one to two years. Those patients with extrinsic growths have a shorter course, due to starvation resulting from dysphagia.

Case Report

The patient, a 64 year old white married woman, was admitted to Mercy Hospital, Canton, Ohio, in 1946. She complained of intermittent hoarseness and a sensation of constriction in her laryngeal area for one year. There was no history of smoking of tobacco or drink-

ing alcoholic beverages. The Kline and Kahn serologic tests were nonreactive.

Laryngoscopic examination revealed a firm, lobulated mass, occupying one-half of the lumen of trachea, immediately beneath the right vocal cord. The tumor was removed through a laryngofissure and its base was cauterized. Histologic examination showed that the tumor was an adenocarcinoma.

Following surgery the patient had no symptoms for 10 years, then she developed a gradual but progressive dyspnea. She was readmitted to the hospital, where radiologic examination of the neck revealed a mass extending from C4 to C7, along with some narrowing and displacement of the trachea in the corresponding region. The thyroid cartilage was also eroded by tumor. A total laryngectomy was performed. The tumor consisted of an adenocarcinoma, similar to the neoplasm removed 10 years previously. She left the hospital following an uneventful postoperative course.

Conclusions

The interesting facets in this case are: (1) a rather long course, namely 11 years elapsed from the onset of the hoarseness to the time of the second surgical procedure; (2) the histologic diagnosis, adenocarcinoma, which is encountered in less than two per cent of laryngeal carcinomas; and (3) the intrinsic location of the tumor as compared to the predominately extrinsic distribution of laryngeal cancer in women.

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Chorioretinitis

A Case Report on Preventable Blindness

WILLIAM H. HAVENER, M.D.*

Case Report

Four years ago this woman (now 33) had a poorly-described attack of blurred vision which was ascribed by her physician to "driving in too much sunlight." Apparently this left no noticeable residual defect, since she had almost forgotten the episode. Six weeks ago she was disturbed by slight indistinctness of vision, and discovered that with her left eye alone, vision was slightly blurred. With the right eye alone, she was unable to read or recognize friends, although side vision was intact. Four steroid tablets daily were prescribed and taken for three weeks, without noticeable improvement.

When first seen by consultant three weeks ago, vision right eye was 20/200; left eye 20/30. External and fundus examination were entirely normal except for the macular regions. The right macula was completely destroyed by extensive scarring of old chorioretinitis, measuring 2 by 3 disc diameters in area. Just below the left macula was a one disc diameter focus of active chorioretinitis. Visual field studies at one meter distance from the eye showed a central scotoma (area of absent vision) approximately one foot in diameter O. D. The scotoma O. S. was about four inches in diameter, less dense, and encroached only slightly upon central vision.

Emergency hospitalization was arranged, and under the supervision of an endocrinologist, very high level steroid therapy was begun (20 mg. Decadron [dexamethasone] daily—40 tablets). Within four days the scotoma O. S. decreased to less than one inch in diameter, and receded from the center. Vision improved to 20/20. Simultaneous improvement in appearance was recognizable ophthalmoscopically. After one week she was discharged on 12 tablets daily. During the next four to six weeks a very slow tapering off of steroid will be guided by ophthalmoscopic and perimetric findings. It is anticipated that only an insignificant paracentral scotoma will remain O. S. Unfortunately, the right macula is irrevocably destroyed.

Discussion

Chorioretinitis is a not uncommon disease of children and young adults. It varies in severity from an asymptomatic, peripheral lesion to a fulminating inflammation which reduces the eye to a phthisical and useless remnant. Approximately 8 per cent of blindness is attributed to uveitis (inflammation of the choroid, ciliary body, or iris).

Etiologic diagnosis of the great majority of cases is grossly unsatisfactory. Owing to the understandable reluctance of patient and physician to sacrifice an eye, specimens are rarely obtained during the period of acute inflammation when organisms can be recovered. Diagnostic studies are therefore indirect, and include serologic examination, skin testing, x-rays, etc. Among the diseases known to cause chorioretinitis are toxoplasmosis, tuberculosis, syphilis, sarcoid, brucellosis, herpes zoster, and a host of other viruses and bacteria. Foci of infection in the teeth, sinuses, or elsewhere in the body are sometimes blamed for the eye lesion, though it has become deservedly

unpopular to remove infected organs indiscriminately. Experimentally, uveitis is easily produced by sensitizing the eye to bacterial or animal proteins.

Symptoms of chorioretinitis vary with the location and severity of the lesion. Macular chorioretinitis is ordinarily recognized promptly because of blurred vision. The relatively sudden onset of blurred vision should always be regarded seriously, and chorioretinitis considered in the differential diagnosis. Peripheral chorioretinitis is asymptomatic unless vitreous involvement occurs. The careful ophthalmoscopist is always amazed at the number of cases with old peripheral chorioretinitis scars who do not remember ever having had eye symptoms. If the inflammation breaks through the vitreous face, many inflammatory cells will enter the vitreous and become "floaters." The patient recognizes these as multiple tiny opacities which float about with movement of his eye. Sudden onset of many vitreous floaters is always to be regarded with great concern, and requires careful ophthalmoscopic examination *through a dilated pupil*. Redness of the eye and pain do *not* occur with chorioretinitis, but only if the iris or ciliary body are also inflamed.

The prognosis of chorioretinitis depends upon the severity of involvement and the adequacy of treatment. Many cases heal spontaneously, but an appreciable number progress despite all known therapy. Fortunately, proper therapy will minimize the extent of scarring and preserve vision in many cases which would be lost without treatment. Recurrences in the same or opposite eye are common.

The most satisfactory treatment is use of systemic steroids. (Topical medications will not penetrate deeper into the eye than can be seen with a flashlight; e. g., conjunctiva, cornea, iris, episclera, but *not* retina or choroid). Fairly high doses are necessary (not as high as this case, which was considered a great emergency since her only remaining macula was encroached upon). Most cases require a month or more of treatment, which should be supervised closely (perimetric and ophthalmoscopic examination every several days initially). The usual side effects of steroids are hazards (this lady developed mild diabetes during treatments). Antibiotics are almost never effective unless a specific etiology (such as tuberculosis) is diagnosed. Search for the etiology is generally instituted—and is rarely rewarding. Cycloplegics are useful only if the anterior portions of the uveal tract are also inflamed (which is not uncommon).

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MATERNAL HEALTH IN OHIO

Case No. 157

The patient was a 24 year old white woman, gravida III, Para II, who died upon being given a spinal anesthetic. The past and family histories were negative. Her two previous pregnancies and deliveries were normal. The present pregnancy was uneventful and she had received adequate, regular prenatal care. An x-ray taken in the last month of gestation disclosed twins, the first a breech, the second a vertex and an "apparent interlocking of the chins."

On April 9, at 5:00 a.m., she was admitted to the hospital in labor with membranes intact. In view of the x-ray findings she was seen in consultation and the consultant agreed that she should be delivered by cesarean section.

She was given low spinal Pontocaine® anesthesia and had just been given 3 cubic centimeters of a 1 gram to 20 cc. of water/sodium Pentothal® mixture intravenously, when her respiration suddenly ceased. She was given artificial respiration by means of a respirator but she did not respond and her heart stopped. An immediate *postmortem* section was done at 9:00 a.m., April 10, effecting the delivery of two living babies. (Ohio State M. J., 54: 1315-1317, October, 1938). An autopsy was not done.

Cause of Death: Respiratory paralysis.

Comment

The Committee on reviewing this case felt that this was a preventable maternal death. Since available details are meager, one cannot help but raise the following questions: Was this spinal as "low" as anticipated? How much Pontocaine was given? Was the solution allowed to diffuse before the patient's head was elevated? Was the medication administered during a contraction? Was the patient intubated and placed on forced respiration? Members felt this case points out the importance of skilled, trained anesthesia personnel in the operation of any maternity unit.

Case No. 201

This patient was a 35 year old Negro, Para IX, Cesarean I, who died approximately five hours postpartum. Her past history was essentially normal and her prenatal course uneventful. Her eight previous pregnancies had all been delivered at term. There had been some increasing difficulty with the deliveries, due to a small pelvic outlet and an increasing size of each succeeding baby. She was admitted on August 24, at 8:10 a.m., apparently in desultory labor. However, she subsequently went into an active labor, which continued for some 28 hours.

An x-ray of her pelvis confirmed the fact that she

TOPIC THIS MONTH:

Maternal Deaths* Involving Anesthesia

had a small outlet and consultation was sought. The consultant felt that to avoid prolongation of the apparently futile contractions and to avoid possible rupture of the uterus, a cesarean section should be done. This was done on August 26, at 9:10 p.m., under a caudal anesthesia, apparently supplemented by cyclopropane. A normal 8 pound 12 ounce infant was delivered and the section almost completed when the patient suddenly developed respiratory difficulty. She appeared unable to exchange oxygen and became cyanotic. A thoracic surgeon was called and promptly responded, but by that time she had developed a cardiac arrest. A thoracotomy was done and cardiac massage performed and a fairly regular rhythm restored. The heart suddenly stopped and could not be restarted. Autopsy done.

Cause of Death: Asphyxia; atelectasis; obstruction of bronchi with aspirated secretions; surgical anesthesia; status postcesarean section and cardiac massage.

Pathological Diagnosis: Hemothorax (1,000 cc., post cardiac massage); hemopericardium; pulmonary congestion and atelectasis; mucoid debris in bronchi; gastric dilatation (gas has odor resembling ether).

Comment

The Committee voted this a preventable maternal death. There is but little information available as to why cyclopropane was administered, but the caudal anesthesia drug (administered by physician) was supplemented by general anesthesia (including ether?) administered by a nurse anesthetist. So, when this patient vomited and aspirated there was no one immediately available to suction the mucus, to insert the endotracheal tube or to use a bronchoscope to aspirate the trachea and bronchi. Cardiac massage without an adequate airway was fruitless. Records do not state

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by official representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

whether or not Pituitrin® was administered during the use of cyclopropane.

Case No. 209

This patient was an 18 year old Negro, primigravida, who died five hours postpartum. Her past history was essentially normal. Her prenatal course was entirely uneventful and her care excellent.

She spontaneously went into labor and was admitted to the hospital at 7:30 a. m., September 5. At 9:35 a. m. she was medicated with Doriden® 1 gram. At 12 Noon her membranes ruptured spontaneously. Examination showed the cervix to be 5 cm. dilated, the head at a plus 1 station and the fetal heart to be good. Her labor was good and she was given 200 mg. of Seconal.® At 2:00 p. m. with the cervix 7 cm. dilated and the head at station plus 2, an epidural block consisting of a 4 cc. test and a 12 cc. dose of Metycaine® was done at L-4.

The patient was placed on her back, her pain was relieved, her legs became numb. A rectal examination showed dilatation to be complete with the head near the pelvic floor. Five minutes after the "block" her blood pressure dropped to 90/70. An infusion was started (contents unknown). The patient stopped breathing and was intubated and moved to the delivery room at 2:10 p. m., where she was started on "bag breathing" with oxygen. No blood pressure was obtainable. Vasopressors were given. By 2:35 p. m. a consultant opened the chest and the heart was found to be fibrillating. Failing at first with potassium chloride, successful defibrillation was obtained with the defibrillator and the thoracotomy closed.

At 3:11 p. m. a mid forceps delivery of a 5 pound 8 ounce stillborn fetus was accomplished with resulting bilateral sulcus tears. The patient appeared to be exchanging air adequately and her blood pressure at 3:15 p. m. was 150/80. The epidural ethylene catheter revealed no blood or spinal fluid before it was withdrawn. Despite supportive treatment the patient's condition gradually deteriorated and she expired at 8:40 p. m. An autopsy was refused.

Cause of Death: (certificate) cardiac arrest; cerebral anoxia; delivery of 35 week stillborn fetus.

Comment

The Committee reviewing this case voted it a preventable maternal death. Members discussed the case at great length, and felt death was attributable to the administration of an anesthetic. The mechanism might have been either rapid absorption of the Metycaine with toxicity and myocardial damage; or perhaps more likely an inadvertent, unrecognized high spinal anesthesia with respiratory paralysis. Apparently labor was progressing well prior to administration of that agent.

Comment of Consultant

The following comment of a consultant, who is a specialist in Anesthesiology, was given at the request of the Committee.

This consultant is very much in accord with the findings and comments of the Committee with one small exception. We feel that any verdict of "preventable deaths" is not only a very fair verdict, but one that is entirely unescapable. In regard to the Committee's comment on Case No. 209, where the Committee cites a possibility of the mechanism of rapid absorption of the drug as a possible

cause of death, we feel that this possibility is so very remote that it is not worthy of citation.

In reviewing these three cases, your consultant was impressed with several rather constant factors. First of all, the data presented concerned the anesthesia in these cases, and the notations of the condition of the patient before, during, and after the anesthesia as regards to pulse, blood pressure, respiration, etc., were so meager, as were the data regarding dosage, technique employed, and reasons for its employment, that we could not help but wonder if this information was even gathered by the anesthetist in question.

Second, we were struck by the fact that all three of these patients had received some form of regional anesthesia.

There can be no doubt that regional anesthesia, in capable hands, is the number one choice in obstetrical analgesia. A point that is often overlooked is that regional techniques require as great, if not greater, skill on the part of the anesthesiologist. Also the use of regional anesthesia in no means precludes the necessity for the anesthetist having the ability to adequately handle the *airway problem*.

The next fact which stood out in these three cases was that in two of them a regional anesthesia was supplemented with some form of general anesthesia. It is our feeling that the supplementation of regional anesthesia in obstetrics is not only usually unnecessary, but almost always very unwise. If you supplement the regional type of anesthesia, you thereby eliminate one of the primary reasons for its selection in the first place. You are also increasing the hazard of hypotension, both to mother and child, and are confusing, if not eradicating, many of the vital signs which are a very necessary guidepost to the condition of mother and baby. If the regional anesthesia selected has not been effective or is not adequate, then it should either be repeated or supplemented by local infiltration anesthesia.

We can never forget that epidural anesthesia can create a very marked hypotension, as severe if not more severe, than that of spinal, and we must always remember that adequate oxygen must be supplied to both mother and baby.

All supplemental general anesthesia, if it is to be used, should be withheld until the baby has been delivered. If at this time the mother is having pain or is restless, then light general anesthesia may be instituted.

It has been said many, many times, but we feel should be printed in large letters in every obstetrical department: "DEATH IS A HORRIBLE PRICE TO PAY FOR THE RELIEF OF PAIN."

Proceedings of the Ohio Society of Pathologists

Reported by PAUL N. JOLLY, M.D., Cincinnati, Ohio

THE fall meeting of the Ohio Society of Pathologists was held at the Department of Pathology, Cincinnati General Hospital on Saturday, September 20, 1958, at 2:00 p. m.

Scientific Program

The entire scientific session was devoted to a seminar on tumors of soft tissues. Serving as moderator was Dr. Richard Shuman, Chief of the Soft Tissue Tumor Registry of the Armed Forces Institute of Pathology, Washington, D. C.

Soft tissue tumors are a heteromorphous group of lesions of inflammatory, benign neoplastic, or malignant neoplastic origin. A rational classification on the basis of cell origin is fraught with difficulties, and the entire group of lesions present great difficulties in differential diagnosis. The most rational classification arises from a careful correlation of the pathology of the lesion with the clinical behavior. From Dr. Shuman's experience with such correlation, he offered a series of slides considered to be representative of a group of lesions which offer particular differential diagnostic problems but in which the correct diagnosis is quite important because of the clinical implications.

Abstracts of Cases from Slide Library

Slide 664: This lesion is of uncertain pathogenesis usually found in the subcutaneous tissues but occasionally in the muscles. The latter location is demonstrated in this case. Although fairly circumscribed, it shows an infiltrative type of growth around the periphery with invasion of the muscles and formation of muscle giant cells. It is made up of interlacing bundles of spindle cells in which the nuclei are fairly uniform and in which mitoses are occasionally observed. The outstanding characteristic of this lesion is alternating areas of rather compact fibrous tissue and scattered, loose areas in which the cells are swollen and hydropic. Interstitial fluid is present, and small numbers of inflammatory cells are seen. Special stains indicate that only small amounts of collagen are laid down in this lesion.

This process is non-neoplastic and must be differentiated from sarcomas. It runs a benign clinical course and if adequately excised rarely recurs. It occurs at any age, more commonly in males and shows a predilection for the volar surface of the upper extremity. It is usually characterized by an initial period of rapid growth clinically suggestive of sarcoma. It rarely exceeds 3 cm. in diameter.

Diagnosis: *Infiltrating fasciitis*.

Slide 665: This represents another lesion which must be differentiated from a fibrosarcoma. The gross appearance of these lesions is quite similar to that of the uterine leiomyomata, with a sharply defined periphery and a cut surface made up of irregular whorls of dense white connective tissue. Histologically the lesion is

characterized by bundles of mature spindle cells, between which there is abundant collagen. There is atrophy of the surrounding muscle with the formation of muscle giant cells, but in some places the musculofascial planes seemed to be preserved. More cellular areas with plumper cells occur where the bundles are cut in cross section, rather than longitudinally. The cells are regular and there are only a few mitoses. There is some extension into the adjacent fat, but nerves and other structures surrounded by the lesion show preservation of their architecture.

The fibromatoses, of which this is an example, are of two main types. The nonaggressive group occur commonly in the abdominal wall of pregnant women as desmoid tumors. This type is also found in men and children, and they occur rather frequently in the palmar and plantar fascia and as the cause of torticollis. The aggressive group have a predilection for the shoulder region, the inguinal region, the omentum, the periosteum and the dorsum of the foot. Both groups of lesions are usually solitary, but they may be multiple.

The clinical behavior is impossible to predict on pathologic evidence alone. Recurrences are particularly common in the aggressive group, but no metastases from such lesions have been recorded. The preferred initial therapy is a radical local excision, while recurrences are best treated by radiation therapy.

Diagnosis: *Aggressive fibromatosis*.

Slide 666: Large tissue sections indicate that this is an intracutaneous lesion with subcutaneous extension. It is made up of large numbers of plump spindle cells arranged in whorls. Within some of the whorls is a very characteristic pattern identified as a spoke-wheel pattern. In spite of the histologic anaplasia of these spindle cells with their plump nuclei, mitoses are rarely encountered. Special stains indicate only a small amount of collagen. Foam cells containing fat are present in small numbers and best identified by fat stains; iron pigment can also be identified. The recurrent lesions commonly assume a myxomatous appearance with a vascular framework.

These tumors are slowly growing nodules which occasionally produce ulceration of the skin. Recurrences are sometimes delayed for a period of many years. The primary lesion is usually a solitary nodule occurring most commonly along the milk line, but it may also involve the extremities and other portions of the body. Recurrences are usually multinodular. It is important to differentiate this lesion from the fibrosarcoma, since metastases have rarely been reported with this lesion, and in such cases the validity of the diagnosis may be questioned.

Diagnosis: *Dermatofibrosarcoma protuberans*.

Slide 667: Clinical information indicated that this patient had von Recklinghausen's disease. The most common tumors occurring in the posterior mediastinum are of neurogenic origin.

The specimen consists of strands of cells with wavy, elongated nuclei and abundant collagen. These elements are arranged in interdigitating or herringbone patterns. The cells and their nuclei are fairly well-differentiated and mitoses are infrequent. Portions of the lesion show a myxomatous type of degeneration and nerves can be identified in the capsule of the tumor or within the lesion.

In the following discussion, Dr. Shuman indicated the importance of differentiating the tumors of neurilemmal origin and those of Schwann cell origin. The former, although showing areas of myxomatous degeneration

and cellular pleomorphism, rarely have a clinically malignant course, while such features in tumors of Schwann cell origin usually indicate a poor prognosis. In general, malignancy is more apt to occur in nerve sheath lesions of Schwann cell origin than in those of neurilemmal origin. The schwannoma more commonly involves deep nerves, is usually solitary and is made up of plump cells, while the neurilemmona is composed of cells more like normal fibroblasts. The latter is commonly encapsulated and contains nerve fibers in the capsule, has thick hyalinized blood vessels and shows the morphologic features of the Antoni-B patterns. Neurocytes are more commonly observed in lesions of Schwann cell origin.

Diagnosis: *Neurogenic sarcoma*.

Slide 668: On the basis of clinical or histologic evidence, three diagnoses would be possible in this lesion. Metastatic carcinoma from the bladder seems unlikely in view of the morphology of the lesion. There is similar objection to a mesothelioma of the fibrous type. The third possibility is a post-inflammatory pseudo-tumor.

The basic architecture of the lesion is similar to that of a sclerosing hemangioma or of a dermatofibrosarcoma. It is made up of spindle cells arranged in whorls and "spiral nebulæ." An inflammatory component is seen in the form of Touton giant foam cells and small numbers of lymphocytes. Frequently the spindle cells have perivascular arrangement, a feature which is commonly encountered in other tumors and inflammatory conditions. Scattered areas of degeneration are associated with a loss of cells in such areas. These lesions may also occur in the lungs as a post-inflammatory condition in three forms: a fibrous type, a plasma cell type and a fibroxanthoma type, (the inflammatory cells point away from the diagnosis of mesothelioma).

Diagnosis: *Post-inflammatory pseudo-tumor*.

Slide 669: A variety of terms has been used to identify this lesion. Malignant organoid granular cell myoblastoma, organoid myoblastoma, and non-chromaffin paraganglioma are among the more common.

The basic architecture of the lesion is one of nests and cords of cells, separated by a delicate stroma containing vascular spaces. The cells tend to drop out in the center of many of these nests to produce an alveolar appearance. The cells have an abundant pink cytoplasm and an eccentric vesicular nucleus. Cytoplasmic granules are consistently demonstrated by the use of the periodic acid stains.

These tumors occur in younger individuals with a peak incidence between the ages of 15 and 25. They grow slowly, are usually asymptomatic, and tend to involve muscles and other deep locations. Grossly they are circumscribed and encapsulated, but they metastasize readily via the blood stream to the lungs, brain and other viscera. The mortality rate is between 40 and 60 per cent.

Diagnosis: *Alveolar soft part sarcoma*.

Slide 670: This lesion presents a biphasic pattern with cylindrical and cuboidal cells lining spaces containing a mucinous fluid. Similar cells are occasionally found outside of these cysts and they blend imperceptibly into the second pattern made up of interlacing bundles of spindle cells. Into some of these cysts project small intraluminal knobs and cellular nests. No basement membrane surrounds these cell nests. The plump spindle cells making up the basic stroma probably represent a variant of the lining cell or a fibrosarcomatous component. Occasionally small scattered foci of calcification are encountered.

Metastases to the lungs occur commonly but they rarely include the cuboidal cells. The pulmonary metastases may have a peritheliomatous pattern, a reticulum cell sarcoma pattern or an epithelium-like pattern. Florid villonodular synovitis may simulate this lesion.

This tumor commonly occurs near the larger joints around bursae, in tendon sheaths and periarticular tissues, but it rarely, if ever, arises in joints. It is found

chiefly in younger people with a peak incidence about 30 years of age. Although it grows slowly, metastases occur almost inevitably, and very few patients can be cured.

Diagnosis: *Synovial sarcoma*.

Slide 671: A review of the x-rays of the patient revealed a circumscribed soft tissue mass, which was more densely calcified in the center than around the margins.

Histologically the lesion is made up of a pleomorphic, polymorphous, anaplastic, connective tissue stroma in which there are numerous giant cells. In many places the stromal cells produce osteoid and in a few areas a cartilaginous matrix can be identified. Some parts are made up chiefly of spindle cells, and others closely resemble a giant cell tumor.

This lesion is a distinct pathologic entity occurring in older people rather than younger individuals as is characteristic of the osseous forms of osteogenic sarcoma. It arises chiefly in periarticular locations and morphologically resembles the osteolytic type, osteogenic sarcoma. It is to be differentiated from the liposarcomas which occasionally show osseous and cartilaginous metaplasia and from malignant giant cell tumors which are rare but highly malignant lesions. This tumor is among the most malignant of soft tissue tumors and metastasizes chiefly to the lungs.

Diagnosis: *Osteogenic sarcoma of soft parts*.

Slide 672: This tumor resembles the so-called rhabdomyosarcoma of the heart, a rare congenital cardiac anomaly. It is also related to the sarcoma botryoides of children.

The sections demonstrate a lobulated structure made up of pleomorphic spindle cells and round cells in a loose, spongy arrangement. Within some of the spongy spaces are found large cells with elongated, thin, protoplasmic processes—the so-called spider cells. In the looser areas spindle cells of extreme length are occasionally encountered. Cross striations are poorly defined at best and are not demonstrable in this case. Appropriate stains can demonstrate the presence of myofibrils and the presence of glycogen within the cytoplasmic vacuoles.

Grossly these tumors are polypoid, gelatinous structures usually found in younger individuals. A urogenital origin is most common but the head and neck are also commonly involved. The lesion almost never arises in skeletal muscle. Heterologous elements within the tumor are rare. Metastatic spread is chiefly to the liver and lungs. Unlike most tumors this lesion tends to remain localized in its most anaplastic forms and only when it shows evidence of differentiation do metastases occur. The undifferentiated elements do not participate in this dissemination and better differentiated but obviously neoplastic skeletal muscle cells can best be identified in the metastases.

Diagnosis: *Rhabdomyosarcoma, embryonal type*.

Slide 673: The perplexing nature of this lesion has led to a variety of terms including anaplastic synovioma, reticulum cell sarcoma of soft parts and angiosarcoma. The tumor is made up chiefly of small round cells which makes its differentiation difficult. These cells arise from muscle cells either within the actual skeletal muscle fiber or within the bundle.

As the cells grow there is a loss of the skeletal muscle fibers but preservation of the fibrous trabeculae. The small cells then form coverings or linings over these fibrous trabeculae to produce a papillary pattern. The small cells cluster around small blood vessels and frequently suggest the presence of rosettes by their perivascular pattern. As the cells differentiate, they become larger and acquire a pink cytoplasm and delicate cytoplasmic processes. The nuclei vary considerably in size, shape and configuration. Cross striations can rarely be identified in the primary tumor and are seen chiefly in the metastases, especially those in the lung.

This tumor arises in voluntary muscle in younger indi-

viduals between the ages of three and 30 years. It is rare after the third decade. The trunk, the extremities, the head and the neck are the primary sites as a rule. The tumor metastasizes to the regional lymph nodes and then via the blood stream to most tissues, and as such offers a problem of differential diagnosis from the neuroblastomas and from leukemias.

Diagnosis: *Embryonal rhabdomyosarcoma, alveolar type.*

Slide 674: This lesion has a myxomatous background and a reticular framework in which there are stellate and spindle cells. In the looser areas the cells are arranged in irregular nests and from these nests cells drop out into the surrounding myxomatous matrix. This tumor is to be differentiated from a liposarcoma with chondral elements in which the foregoing features are uncommon. Generally liposarcoma has a network of fine capillaries through which are distributed vacuolated or signet cells. These cells are positive for fat. In contrast, the characteristic features of this lesion are the micronodules in a myxomatous, mucoid and chondroid matrix. The cells are round and stellate. Calcification and ossification are rarely seen, and the lesion tends to differentiate in the direction of cartilage, a feature unlike that of the osseous types of chondrosarcomas. With invasion of fat, the lesion may contain considerable residual fat as demonstrated by appropriate stains.

The lesion is more malignant than the liposarcomas with chondral elements and metastasizes in about 25 per cent of the cases. It is radioresistant.

Diagnosis: *Chondrosarcoma of soft parts.*

Slide 675: This tumor is characterized by (1) a network of vascular channels lined by endothelial cells which are more conspicuous than usual; (2) intraluminal cellular growths with the production of papillary processes or compact masses containing only small amounts of stroma and (3) cytologic anaplasia of the endothelial cells. Occasionally in such tumors the appearance of benign angiomas of both the capillary and the cavernous patterns may also be reproduced.

This lesion is an uncommon tumor, arising in the breast of women between the ages of 21 and 61. The mean age is 37. It is characterized clinically by a diffuse, indefinite fullness of the breast with gross enlargement and local tenderness. Rarely it is bilateral. Grossly the tumor is poorly circumscribed, infiltrating and shows stellate projections into the surrounding fibrous and fatty stroma. Widespread metastases to the lungs, liver, ovary and other viscera occur early, and the lesion is rapidly fatal.

Diagnosis: *Angiosarcoma of breast.*

Slide 676: This lesion is uncommon and of controversial origin and nature. Although histologically malignant, it is a reactive and non-neoplastic process. Histologically the lesion is intracutaneous, circumscribed, hard and nodular. Early the superficial dermis and the epidermis are uninvolved but later extension towards the surface may produce superficial ulceration. The tumor is made up of pleomorphic spindle and polyhedral cells and large giant cells. The nuclei are vesicular and frequently show mitoses. Chromatin is irregularly clumped in many nuclei, particularly in the giant cells. The cytoplasm is abundant, oxyphilic, slightly granular and occasionally foamy. Fat can be demonstrated occasionally in the cytoplasmic vacuoles. Stroma is generally scant.

Although the lesion has been identified in individuals ranging from 14 to 92 years of age, it occurs more commonly in older individuals and shows a predilection for the face and extremities. It runs a prolonged, innocuous clinical course, ranging up to 20 years, and only one recurrence has been encountered.

The lesion is to be differentiated from a variety of malignant neoplasms including melanoma, rhabdomyosarcoma, liposarcoma, Kaposi's sarcoma and fibrosarcoma.

Diagnosis: *Fibroxanthoma.*

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEFFEL, M. D.
Columbus, Ohio, Chairman

Following is the summary of a case which was discussed before the Franklin County Pelvic Cancer Delay Committee on July 17, 1959, at its regular monthly meeting held at the University Health Center.

Case No. 71. The conference reviewed the case of a 64 year old white woman who gave the history of having had a subtotal hysterectomy 20 years prior to admission. This subtotal hysterectomy was done for uterine fibroid tumor. Six months prior to admission the patient developed vaginal bleeding. She reported to her local physician one month ago and he took a specimen of the cervical stump for biopsy. Diagnosis returned was "carcinoma of the cervical stump, clinical stage II."

Comments

DR. POMEROY: Therapy is, of course, complicated because of proximity of the bladder over the cervical stump which prevents giving as large a dose as we ordinarily do.

DR. BOUTSELIS: It seems strange that we are still seeing the cervical stump cases. The disease of this cervix would have been prevented by complete hysterectomy.

DR. HOLZAEFFEL: This is another of the long line of cervical stump cases appearing at the Gynecological Tumor Clinic. Since 1940, we have now accumulated a total of 92 cases of cervical stump cancer. This represents 5.4 per cent of the total 1700 patients registered. With but rare exceptions, hysterectomies should be total hysterectomies. *Patient delay* five months. *Physician delay* one month, if one considers the recent symptomatology; if one considers the length of time since subtotal hysterectomy, an answer cannot be given.

Serum Cholesterol Concentration Decreased by Neomycin

Oral neomycin produced a significant decrease in serum cholesterol concentration in all of 10 patients, none of whom had known gastrointestinal disease. In those receiving daily doses of 1.5 to 2 Gm., the mean serum cholesterol level fell by 17 to 29 per cent (average of 22 per cent), and the fall was maintained for the 3 to 16 weeks that neomycin was continued. Daily doses of 0.5 to 1 Gm. produced similar but less marked falls in serum cholesterol.—(*Abstract*); Paul Samuel and Alfred Steiner, M.D., New York City: *Soc. Exptl. Biol. Med., Proc.* 100:193-195, January, 1959.

A Clinicopathological Conference

Edited Under the Auspices of the Ohio Society of Pathologists

CHARLES BLUMSTEIN, M. D., *President*

Presentation of Case

THIS 42 year old Negro woman was admitted to the University Hospital, Columbus, Ohio, six days prior to her death with the chief complaint of a skin rash of 24 hours' duration. Eight days prior to admission the patient had a cyst removed from her left thigh and at that time she received an injection of Demerol® and another of procaine. Following surgery she complained of malaise and pain in her left leg. Two days prior to admission she developed a sore throat, cough, mild dysphagia, swollen nodes in her neck, acute conjunctivitis and photophobia, accompanied by moderate lethargy and anorexia. One day prior to admission she developed itching rash over her back which spread over her chest, abdomen, face, neck, buttocks and thighs. She was given oral penicillin, and hydrocortisone ointment for her eyes. On the day of admission the rash became confluent, resulting in the formation of bullae; the skin of her back began to peel and her temperature rose to 105° Fahrenheit.

Physical Examination

The patient was a well developed, well nourished Negro woman who appeared in marked acute distress. Her blood pressure was 120/70, pulse rate 120 per minute, respiratory rate 24 per minute, temperature 104°F. Her skin presented a confluent violaceous pemphigoid rash over her face, neck, chest, back, abdomen, thighs, palms of her hands and soles of her feet. The typical lesion consisted of bullae with wrinkled centers which were surrounded by zones of inflammation. In a few areas a discrete macular rash was present. The skin of her back was peeling.

Her left ear drum was injected. She had a marked conjunctivitis and injection of the sclerae, but the iris was not involved. The nose was swollen. Her lips were swollen, peeling and slightly bleeding. Her gums were purple and hemorrhagic. There were small ulcerations on her oral mucosa, and the roof of the mouth was covered with a patchy gray membrane. Her throat was markedly injected, but the tonsils were not markedly enlarged. Her pharynx and the anterior and posterior pillars were markedly reddened. There was an anterior cervical lymphadenopathy and the nodes were soft and tender.

Her lungs were clear to percussion and auscultation.

Presented by

- Wiley L. Forman, M. D., Columbus, and
 - Colin R. Macpherson, M. D., Columbus.
- Edited by Emmerich von Haam, M. D., Columbus.

Her heart rhythm was normal and there were no murmurs. Her abdomen was soft, non-tender and somewhat tympanitic to percussion. Liver and spleen were not palpable. The rectal examination revealed prominent external hemorrhoids. On the lower anterior left thigh there was a recent surgical incision 1½ inches long, which was surrounded by an area of inflammation but did not appear infected. The neurological examination gave no significant abnormalities.

Laboratory Data

On admission urinalysis showed pH of 5.5, protein 120 mg., many fine and coarse granular casts and many white blood cells. The white blood cell count was 7,400/cu. mm. with 18 per cent nonsegmented and 74 per cent segmented neutrophils, 7 per cent lymphocytes and 1 per cent monocytes; hematocrit was 51.5 per cent and hemoglobin 16 Gm. Wintrobe sedimentation rate (corrected) was 30 mm. in one hour. The blood urea nitrogen was 20 mg.; fasting blood sugar 225 mg.; sodium 135 mEq., potassium 3.9 mEq., chlorides 100 mEq., and CO₂ combining power 56 vol. per cent. The serologic test for syphilis was negative. Culture of the throat exhibited a moderate growth of *Hemophilus hemolyticus*. Culture of the urine presented a moderate growth of coliform bacilli and *Proteus*.

Hospital Course

Four hours after her admission the patient had a temperature of 106°F. and she continued to have daily fever up to 104 or 105°. The patient was started on whole blood and also received saline, and colloids in the form of plasma and albumin. Her initial treatment also included relatively large doses of steroid derivatives, both intravenously and parenterally, antihistaminics and some local therapy to ease the itching. However, on her third hospital day her white blood count dropped to 2,200/cu. mm. with 66 per cent granulocytes, her

hematocrit was 45 per cent, and her hemoglobin 14.2 Gm.

On her fourth hospital day a bone marrow examination revealed predominant myeloid elements at the C level, a relative decrease in erythroid elements, numerous phagocytic clasmotocytes and some increase in eosinophilic myelocytes. Her hemogram revealed a white blood count of 1,100/cu. mm. with 48 per cent nonsegmented and 16 per cent segmented neutrophils, 34 per cent lymphocytes and 2 per cent monocytes. Her airway became a problem and the patient could not handle her bronchial secretions; a tracheotomy was performed with good results. On her fifth hospital day her blood pressure began to drop and did not respond to administration of blood; however, she had some response to Neo-Synephrine.®

Subsequent urine examinations continued to show proteinuria and pyuria. A repeat hemogram revealed white blood count of 1200/cu. mm. with 24 per cent myelocytes, 40 per cent nonsegmented and 18 per cent segmented neutrophils and 18 per cent lymphocytes. There was a marked decrease of her urinary output, and her electrolytes were reported as sodium 170 mEq., potassium 4.1 mEq., and chlorides 112 mEq. During her last hospital day her urinary output was nil, her blood pressure started to fall and she required Levophed® to maintain it. However, later in the day her blood pressure was unobtainable despite large amounts of Levophed. She developed prolonged expiratory phases, her face became markedly edematous, and she finally stopped breathing and was pronounced dead in the morning of her seventh hospital day.

Clinical Discussion

DR. FORMAN: This patient had certainly an acute illness, which lasted only 14 days. Several days following minor surgery she developed a systemic response to something that had happened to her in these several days; whether it had anything to do with the surgery remains to be seen. She presented symptoms which reflected some sensitivity to something that had happened to her in the past, and these symptoms rapidly got worse. Along with this she developed a rash which was described as generalized and bullous in character. It is interesting that the bullae were surrounded by a zone of inflammation and that they were accompanied by a discrete macular rash.

This is not the typical picture of pemphigus but makes one think more of the so-called erythema multiforme bullosum or exudativum. That is a generalized systemic skin response to a number of things that we will discuss a little later on. As I say, the characteristic part of the bullous

lesion in itself tends to take it out of the pemphigus class. Another thing that speaks against pemphigus is that pemphigus, although often a fatal disease, is usually not fatal in less than two to three months and may persist for several years. This patient died within a matter of six to eight days after developing the bullous type of lesion which she presented.

Generalized lymphadenopathy was present in the beginning, which is a common occurrence in individuals who develop a sensitivity phenomenon. The surgical incision seemed not to be infected but was associated with signs of inflammation. The laboratory data also are not particularly helpful. The urinalysis is probably reflecting cloudy swelling of the kidney in an individual who is obviously actually ill. The white blood cell count on admission was within normal limits, and there was no anemia. She ran a downhill course with high fever and rapidly went into shock, requiring Levophed, blood and plasma expanders to maintain her blood pressure. Because of the dropping white blood cell count she also undoubtedly became an easy prey to secondary invaders of the respiratory tract.

As the white cells started to drop, the staff was probably wondering what was going on in the bone marrow and a subsequent marrow study was done in order to rule out leukemia, which was suggested by the lesions of the mouth and gums. They found a leukopenia rather than an overproduction of white cells, with numerous clasmotocytes and eosinophilic myelocytes. Clasmotocytes as well as mast cells are quite commonly seen in the bone marrow of individuals who develop large bullous lesions of the skin and may be found not only in erythema multiforme bullosum or exudativum, but also in pemphigus. As a matter of fact, there is one form of chronic pemphigus in which clasmotocytes and mast cells are quite prominent. This is known as mastocytosis.

The increase of eosinophils in the bone marrow again is a response of the bone marrow whenever the skin is markedly involved, and I would suspect that her peripheral blood would have shown an increased number of eosinophils if she had not developed agranulocytosis. During her last hospital days the urinary output fell to zero, which undoubtedly was simply caused by the low renal filtration pressure as she went into shock.

Summary

In summary, then, we have here a patient who died after developing diffuse skin lesions and high fever within six days. Her disease, although recognized as a clinical entity, is really a syndrome,

as it has many causes none of which seems specific. Among the factors known to produce this syndrome are drugs, notably sulfonamides such as sulfadiazine and sulfathiazole. More recently we find reports that Butazolidin® may be doing the same. However, the only drugs this woman had in the most recent past were procaine and Demerol. I know of no instance in which Demerol produced this syndrome. We still see local reactions to procaine in some sensitive individuals in the form of hives, angioneurotic edema or asthma, and there are a few reported cases of sudden death. However, I found no instance in the literature of the past 10 years in which erythema multiforme bullosum was directly attributable to the use of procaine.

The patient also received oral penicillin and of course penicillin has been known to produce generalized systemic effects of somewhat similar nature. But let me remind you that this patient had already begun to develop her skin rash and her systemic symptoms before penicillin was administered. So I am not inclined to blame it on penicillin although it may have had an aggravating effect.

Other factors that have been considered as cause for erythema bullosum are acute fulminating infections, particularly with coagulase-positive *Staphylococcus aureus*, hemolytic *Streptococcus* and certain viruses. It has also been seen in smallpox or even in chickenpox. We already have ruled out pemphigus by the appearance of the lesion. One always has to think of lymphoma and she did have cervical node enlargement, but it is unusual for patients with lymphoma of the skin to die that quickly. Acute monocytic leukemia could be ruled out by the findings in the peripheral blood and the bone marrow. Atypical lupus erythematosus with bullous formation ought to be considered, but in this case one would be able to see the typical LE cells in the bone marrow or in the peripheral blood.

Conclusion

In conclusion, it is my guess that this patient suffered from erythema multiforme bullosum or exudativum, which is also known as ectodermosis pluriorificialis, or Stevens-Johnson syndrome. It was originally described as a form of bullous erythema multiforme with conjunctivitis, stomatitis and sometimes involvement of the nose, urethra, vagina and anus accompanied by fever and constitutional symptoms. One could also explain her lesions on the basis of an acute necrotizing sensitivity polyarteritis in the upper layers of the skin and elsewhere throughout her body. Because of the marked necrosis that occurred, thrombo-

angiitis obliterans may also be a part of the picture. As in many people who develop hypersensitivity reactions, peculiar granulomatous lesions may be found in the lungs, liver, spleen or kidneys.

General Clinical Discussion

QUESTION: Could this have been smallpox?

DR. FORMAN: The lesion as described does not suggest that to me. I grant you that we do see sporadic cases of smallpox, but on the basis of frequency alone and the fact that this patient probably was vaccinated, I would not consider it seriously.

QUESTION: How can you explain her vascular collapse?

DR. FORMAN: I think that she was simply so ill that she had adrenal exhaustion.

QUESTION: Have you any additional suggestions as to possible treatment?

DR. FORMAN: The only thing that I might have tried to help diagnosis-wise would have been to excise one of these skin lesions for microscopic examination.

QUESTION: How long after the administration of the drug do you see the skin reaction?

DR. FORMAN: A generalized sensitivity reaction as this woman demonstrated appears seven to nine days after administration of the sensitizing agent, similar to serum sickness.

Clinical Diagnosis

1. Stevens-Johnson syndrome.
2. Agranulocytosis.
3. Bronchopneumonia.
4. Sepsis.

Pathological Diagnosis

1. Stevens-Johnson syndrome.
2. Bilateral bronchopneumonia.
3. Toxic leukopenia.
4. Septicemia.

Pathological Discussion

DR. MACPHERSON: Examination of the skin revealed an extensive exfoliating dermatitis involving practically the entire body. A few small bullae could still be distinguished, but 30 to 40 per cent of the body appeared denuded, the denuded surfaces being very erythematous. The lesion as presented at autopsy resembled very closely an extensive second degree burn. Both lungs were heavier than normal and showed multiple scattered areas of deep red color and firm consistency. The adrenals had a combined weight of 24 grams and showed pale tan cortical zones.

Microscopic Examination

Microscopic sections of the skin lesions showed a separation of the epithelium at the dermo-epi-

dermal junction. There were marked congestion and edema of the subcutaneous tissue but only a moderate inflammatory reaction. Sections of the lungs showed a severe confluent bronchopneumonia of the agranulocytic type with the alveoli filled with fibrinous exudate and the formation of small early abscesses. Heavy bacterial colonization could be demonstrated, which proved on culture to be a coagulase-positive *Staphylococcus*. Sections through the adrenals showed lipid depletion of the cortical cells. There were no histological evidences of kidney damage, and I agree with Dr. Forman that the oliguria and the anuria which this patient showed terminally were purely because of lack of filtration pressure. Had this patient lived longer she would undoubtedly have developed histological renal changes.

With regard to the diagnosis of the skin lesion, I may state that there are three conditions which would be relevant to this diagnosis. One is called acute pemphigus, but here the split usually occurs below the cornified layer of the skin, although splits at the basal cell level may also be observed.

The second and third lesions are extremely difficult to differentiate from each other and I would be inclined to agree that the differentiation of the two as separate entities is rather arguable and tenuous. For this reason I prefer to state that erythema multiforme occurs in a variety of shapes and sizes, one of which is known as Stevens-Johnson syndrome. The classical description of this syndrome is somewhat different from the picture here presented. It commonly occurs in the young male rather than the middle-aged female; it is very rarely fatal and is usually self-limiting. Up to 1954, only 10 autopsy reports of Stevens-Johnson syndrome were known, although the disease itself is not uncommon by any means.

As to the etiology of this condition I cannot offer much constructive thinking. As far as procaine and Demerol are concerned, I cannot eliminate them, but there is no good reason to incriminate them, and the penicillin was given after the onset of her illness. A certain proportion of these cases are recorded as being of unknown etiology and I think that in this case it is better to admit that we just don't know, rather than to try to explain the etiology of this extremely difficult and complicated syndrome, which is known in general as erythema multiforme. The patient did not show any polyarteritis, thromboangiitis obliterans or allergic granulomas. I do not know whether the patient might have developed them had she lived longer, but again there is no known rule about it.

Fluoxymesterone Used To Treat Advanced Breast Cancer

Fluoxymesterone was used to treat advanced breast cancer in 48 patients who had not received previous hormone therapy and in eight who had previously been treated by surgical hypophysectomy. All but one of the patients were postmenopausal. Among the 48 women not previously given any type of hormone therapy, 18 (37.5 per cent) showed striking objective regressions of metastatic breast cancer and 25 (58 per cent) experienced subjective improvement. Compared to previous observations with testosterone propionate, the quality of improvement with fluoxymesterone was similar and the frequency of objective improvement was slightly greater. Among the eight patients who had previously responded to surgical hypophysectomy, fluoxymesterone objectively controlled reactivation of the disease in one, produced subjective improvement in four patients, and may have accelerated the disease process in a patient in whom hypercalcemia occurred within 22 weeks after the drug was started.

Objective improvement was noted primarily in osseous lesions, but it also was noted in lesions of the skin, lymph nodes, and pleura and in the primary breast mass. Objective improvement has lasted for 3 to 17 months (average of 9 months), and many patients were still maintaining their improvement at the time of this report. Fourteen patients are still living among the 19 patients who had objective responses, whereas only 13 are still living among the 37 patients who did not have objective responses to fluoxymesterone.

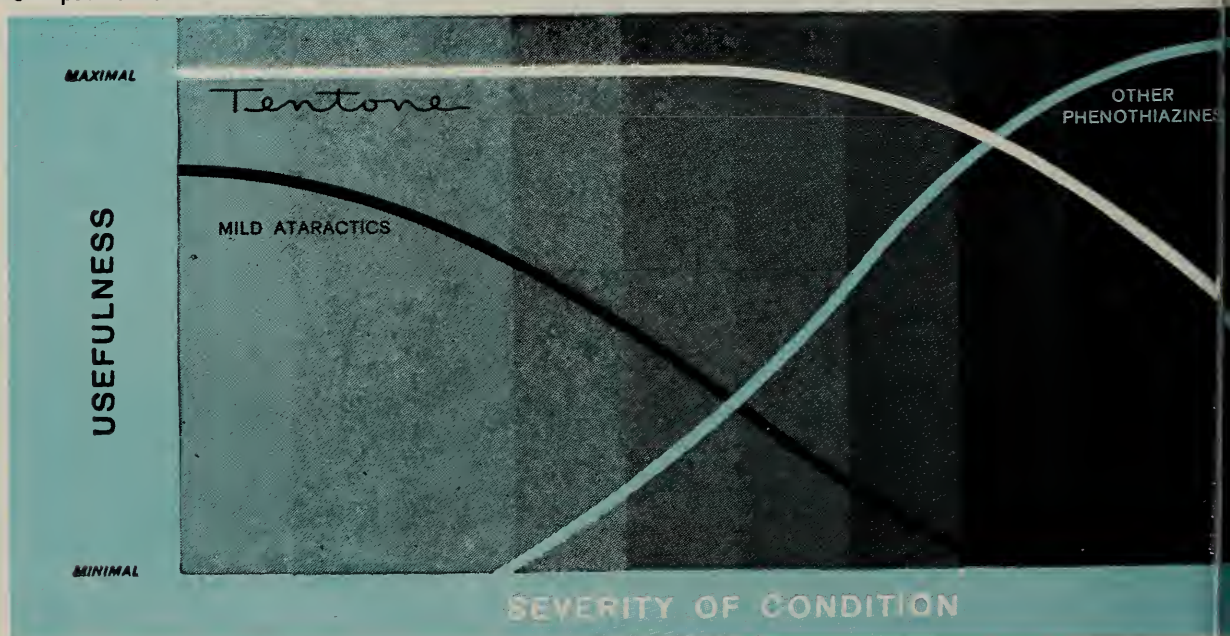
The side effects of fluoxymesterone were observed carefully and compared to those produced in similar patients by testosterone propionate. The unique quality of the side effects of fluoxymesterone suggests that an antitumor effect can be attained without the typical androgenic effects noted with testosterone propionate.—(*Abstract*): Kennedy, B. J., Minneapolis: *New England J. Med.*, 259:673-675, October 2, 1958.

Influence of Steroid Therapy on the Nephrotic Syndrome in Children

Intensive steroid therapy increased considerably the 4-year survival rate in children with the nephrotic syndrome. This conclusion was drawn from the data on 134 cases of nephrotic syndrome of undetermined etiology in which the patient was seen within six months after the onset of edema.—(*Abstract*): Ehrlich, R. M.; Rance, C. P., and Slater, R. J., Toronto: *Canadian M. A. J.*, 80:430-432, March 15, 1959.

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Medical Care Plans . . .

Actions of AMA House of Delegates on Free Choice, Closed Panel Type Programs, County Society Approved Plans, Suggested Future Activities

THE most important item of business transacted at the June meeting of the House of Delegates of the American Medical Association was that relating to the relationship between the medical profession and third-party medical care plans. The purpose of this article is to give Ohio physicians detailed factual information on the policies agreed to.

In adopting the report of a special reference committee on the Report of the Commission on Medical Care Plans, the House of Delegates established policies on many phases of this subject, including free choice of physician.

Considering the lengthy report of the Commission, the reference committee recommended that Part 1 which contains a large amount of information, statistics and conclusions should be filed for "information only" but that the recommendations be taken up separately for consideration and action. This recommendation was adopted by the House of Delegates.

The reference committee then submitted comments and recommendations on the Commission's recommendations. Following are excerpts from the reference committee's report.

Free Choice

"Because one of the components of high quality medical care is free choice of physician, and because great interest has been shown in determination of policy thereon, this subject will be discussed first.

"This House of Delegates considered the concept of free choice of physician sufficiently important to seek an expression of opinion from all constituent medical associations by asking the following question:

" 'Acknowledging the importance of free choice of physician, is this concept to be considered a fundamental principle, incontrovertible, unalterable, and essential to good medical care without qualifications?'

How States Answered

"Forty constituent associations replied. Nine of the forty associations answered, 'Yes.' Sixteen associations *qualified* their answers. Many asso-

ciations stated that the principle of free choice is fundamental but that its application is subject to qualification. Twelve associations answered, 'No.' Three states returned *other* answers.

"Thus, it is to be observed that 22 per cent answered in the affirmative, while a total of 70 per cent either answered, 'No,' or qualified their opinions.

Present Limitations

"In any discussion of the principle of 'free choice,' consideration must be accorded to the limitations listed by the Commission and to the qualifying limitations cited by the constituent medical associations. These factors represent limitations of free choice which patients have accepted voluntarily or which have been imposed upon them and which have been condoned by the medical profession.

"These restrictions on free choice of physician are conditions existing today here and now, notwithstanding any policy implied or expressed by the American Medical Association.

Three References

"Reference to free choice of physician is found in Recommendations A-7, B-11, and B-16 which read as follows:

"A-7. 'Free choice of physician' is an important factor in the provision of good medical care. In order that the principle of 'free choice of physician' be maintained and be fully implemented the medical profession should discharge more vigorously its self-imposed responsibility for assuring the competency of physicians' services and their provision at a cost which people can afford.

"B-11. Those who receive medical care benefits as a result of collective bargaining should have the widest possible choice from among medical care plans for the provision of such care.

"B-16. The principle of 'free choice of physician' should be applied as universally as is practicable. Each plan member should have the widest possible choice of physician. (Ed. Note: See following for revised Recommendation B-16.)

Quality of Care Vital

"Your reference committee at its hearings yesterday heard a wide variety of testimony on free

choice from physicians representing many areas and different types of medical practice. All who testified stated that 'free choice of physician' as a principle should be supported and promoted vigorously by the medical profession. However, in the application of this principle there are exceptions and it is in reference to these exceptions that opinion differs. Despite these exceptions all who testified were in agreement that the principle objective is the highest quality of medical care for all people.

A-7 and B-11 Approved

Many who testified at the reference committee hearings pointed out that if the medical profession had in the past discharged its responsibilities for assuring the competency of physicians as recommended in A-7, it would have prevented many of the problems existing today.

"It is the belief of your reference committee that this recommendation is a forceful and proper statement. It is recommended, therefore, that Commission Recommendation A-7 be adopted. Your reference committee further recommends that the Board of Trustees be requested to transmit to all constituent medical associations the far-reaching significance of this recommendation." (This recommendation was approved.)

"Recommendation B-11 is also a proper statement and reflects much of the opinion expressed during these hearings. This recommendation has been strongly endorsed by the Board of Trustees and your reference committee concurs with this endorsement." (This recommendation was approved.)

"Commission Recommendation B-16 also considers the subject of free choice. This recommendation was questioned by many individuals in the reference committee hearings, and the use of the term "as universally as is practicable" was considered generally unsatisfactory.

New Free Choice Definition

"Your reference committee recommends that this recommendation be not adopted but that the following statement of policy on freedom of choice of physician be substituted:

"The American Medical Association believes that free choice of physician is the right of every individual and one which he should be free to exercise as he chooses.

"Each individual should be accorded the privilege to select and change his physician at will or to select his preferred system of medical care and the American Medical Association vigorously supports the right of

the individual to choose between these alternatives."

This recommendation was adopted by the House.

Closed Panel Plans Poll

The next section of the Reference Committee's report dealt with that portion of the Commission's report covering the attitude of the medical profession toward medical care plans and participation in them. On the matter of physician participation in closed panel plans, the reference committee stated:

What State's Reported

"In order to ascertain the attitude of constituent associations toward physicians participating in medical care plans, this House of Delegates directed that the following question be asked of all constituent medical associations:

"What is or will be your attitude regarding physician participation in those systems of medical care which restrict free choice of physician?

"Replies to this question are as follows: Eighteen constituent associations indicated that physician participation is acceptable. Eight associations submitted qualified answers. Nine associations indicated unacceptability of such participation. Five associations returned other answers.

"Your reference committee considers that these disclosures, together with supporting evidence presented in the hearings, warrant the adoption of policy by the Association in regard to Miscellaneous and Unclassified Plans and physicians associated with them.

Termed Good Suggestions

"In regard to the recommendations concerning the state and county medical society activities (A-1 through A-6) your reference committee is in full accord. Considerable testimony was presented indicating that many of the problems which now exist might have been forestalled or minimized had constituent and component medical societies in past years vigorously carried out the suggestions made in these recommendations.

"In connection with Recommendation A-4, the reference committee notes with gratification the activities of the newly appointed Board of Trustees Medical Disciplinary Committee and believes that its constructive program will assist the medical profession in achieving the intent of this recommendation. Your reference committee recommends adop-

tion of recommendations A-1 through A-6." This recommendation was adopted by the House.

Those Approved

Recommendations A-1 through A-6, concerning activities of state and county medical societies, read as follows and were approved:

"1. County and state medical societies should engage in a continuing review and study of those types of medical care plans which are included in the Miscellaneous and Unclassified category. This study should include an appraisal of practices in the closed panel, direct service, type of medical care plans as well as similar practices existing in the occupational and non-occupational medical care fields.

"2. County and state medical societies should maintain active liaison committees in the medical care plan field in study, advisory and mediation capacities.

"3. County and state societies should consult competent legal counsel familiar with federal and state laws when controversial problems affecting medical care plans arise.

"4. Medical societies should exert more effective efforts to eliminate unnecessary and excessive use and abuse of medical care plan benefits by a small minority of physicians.

"5. State and county medical societies must be alert to legislative activities concerning medical care plans in order that the welfare of the public and the profession is served by sound legislation.

"6. County and state medical societies should be responsive to any demonstrated needs in aiding in the establishment of mutually satisfactory mechanisms for the provision of good medical care to specific segments of the population requiring such service.

Guides for Future

Other recommendations of the Commission—dealing with activities of the AMA, medical care plans generally, medical representation on governing boards and advisory councils, liaison between plans and medical societies, etc.—were approved by the House of Delegates on recommendation of the reference committee, with a few changes by the reference committee. They were as follows:

- Appropriate facilities of the A. M. A. should be utilized to conduct a continuing study of socioeconomic problems and trends as they affect the development and operation of all medical care plans.

Periodic surveys should be conducted in the medical care plan field to follow accurately changes and trends in various categories of medical care plans. Special attention should be given to the

accumulation and use of health and welfare funds in the extension of these prepaid health plans in order to observe their impact on medical practice.

- To permit valid comparisons, uniform criteria should be promulgated and applied to measure utilization of services in medical care plans.

Improved Coverage

- Improvements in coverage should be one of the continuing goals of medical care plans.

- In an effort to decrease, or at least to prevent an increase, in the over-all cost of health care, study should be given to the removal of the requirement of hospital admission as the only condition under which payment of certain benefits will be made.

- Medical schools should be encouraged to devote more teaching time to problems in the socioeconomic field of medical care.

- Medical care plans should be encouraged to increase their efforts to provide health education and information concerning the coverage of their subscribers.

Medical Policies

- Medical policy and medical administration of medical care plans should be controlled by physicians. Purely business functions may be handled by others who are employed for that purpose.

- Governing boards of medical care plans should include physician representation.

- There is no unanimity of opinion as to the scope of service included in "comprehensive medical care," and the use of the term is misleading. Medical care plans which claim to offer "prepaid comprehensive medical care" should clearly describe their exclusions and limitations.

- Each individual should be made aware of the payment made by his employer for his medical care plan.

- Physicians should be encouraged to serve on advisory councils of medical care plans.

- Plans should confer with local and/or state medical societies before embarking on new medical care programs. This will tend to prevent misunderstanding.

AMA Activities

- Increased efforts should be made by appropriate facilities of the A. M. A. to develop information and to discuss controversial problems with sponsors of the plans as well as state or local medical societies and when requested by the parties concerned to develop effective mechanisms for resolving disputes consistent with the policy of

the House of Delegates and the autonomy of the constituent associations.

● An appropriate committee from the A. M. A. should sponsor national and regional conferences with representatives of all parties concerned. Guides for the relationship between the medical profession and these third parties should be considered and developed based upon recognition of the interests and obligations of plan members, physicians, and third parties, as enumerated in Section IV on "Third Party Relationships in Miscellaneous and Unclassified Plans" in the Report of the Committee on Miscellaneous and Unclassified Plans. At such conferences, mechanisms and procedures should be agreed upon for resolving controversies which might exist between the medical profession and these third parties. These mechanisms and procedures should be acceptable to all third parties concerned and to the medical profession, and should be included in the guides, in so far as is possible.

Such a course of action resulting from the Commission's study should be given wide publicity so that all persons and organizations may become well acquainted with, and correctly informed regarding, the policies, beliefs, and constructive efforts of the medical profession in the medical care plan field.

Functions Enumerated

The reference committee suggested that the House of Delegates direct the AMA Division of Socio-Economic Activities to take immediate steps to carry out the purpose of the various recommendations relating to AMA activity, including the following functions:

1. Development of a continuing method for study of socio-economic problems and trends as they affect the development and operation of all medical care plans;

2. Expansion of the periodic surveys in this field now being carried on by the councils in this Division;

3. A continuation of discussion of problems with medical care plans as well as with constituent associations through the type of regional conferences now being carried on by the Council on Medical Service;

4. Greater emphasis on assistance to constituent associations in the resolutions of controversies with medical care plans;

5. Development of guides for the relationship of the medical profession to medical care plans;

6. Greater publicity on the policies, beliefs, and constructive efforts of the medical profession in the medical care field; and

7. Maintenance of an up-to-date library, as now

planned by this Division, of information on all types of medical care plans and the laws relating thereto, with provisions for the use of this information by constituent and component societies requesting assistance.

Memo on Contracts

"The suggestion was made in the hearings of the committee yesterday," the reference committee stated, "that the American Medical Association prepare a form of contract to be entered into between plans and physicians. Because the terms of contract may vary widely, the committee believes a preferable procedure would be for the Law Division of the American Medical Association to prepare a statement which would include all foreseeable points which a physician should consider in contracting with a plan. The committee recommends that the Board of Trustees give consideration to this suggestion."

Medical Society Approved Plans

Regarding that portion of the Commission's report dealing with medical society approved medical care plans, the reference committee made the following observations:

"Your reference committee heard considerable evidence with respect to the following: (1) great strides have already been made by the medical society sponsored plans, such as Blue Shield; (2) future progress depends upon the medical profession in each area sponsoring a plan; (3) the growth of closed panel medical care plans has, in part, resulted from the desire of the individual to provide his family and himself with medical services on a more comprehensive basis than many voluntary medical care plans now provide; and (4) medical society sponsored plans, such as Blue Shield, have provided and can provide more comprehensive medical services and still maintain a high degree of physician participation.

Can Act as Deterrent

"Your reference committee believes that the extension of benefits under these voluntary health insurance plans which offer a free choice of physician can act as a deterrent to the future development of closed panel plans. It has been demonstrated that voluntary plans are generally preferred by the public. The Commission Report includes nine recommendations with reference to medical society approved plans, including Blue Shield and private insurance programs. All of these recommendations could serve to stimulate the voluntary plans to greater progress. Your reference committee recommends approval of these nine recommendations and urges medical societies and

voluntary plans to review these recommendations, the benefit schedules of those plans successfully competing with closed panel plans, and developments that are taking place in some areas."

Expansion of Plans Urged

The nine recommendations referred to and which were approved by the House of Delegates were as follows:

1. Since the preservation of the American system of private practice of medicine may well depend on the success or failure of voluntary health insurance in financing health care costs, it is recommended that the activities within the American Medical Association in matters relating to health insurance be expanded as rapidly as possible.

2. Constituent associations and component societies be encouraged to create or expand their facilities for studying and dealing effectively with insurance programs for financing the costs of health care.

3. All appropriate measures be utilized to discourage insurance plans or programs that might encourage such practices which classify as hospital services those professional services which can only be performed legally by licensed physicians.

4. The American Medical Association continue and encourage constituent associations and component societies to foster free competition among all legitimate types of health insurers which preserve the private practice of medicine.

5. Where constituent associations and component societies choose to endorse plans or programs, the criteria established for recognition or approval should not impose conditions which preclude endorsement to any legitimate type of insurer.

Code of Standards

6. All insurers be required to adhere to the same code or standards of advertising and sales methods prescribed by the insurance regulatory authorities. Constituent associations and component societies electing to approve, sponsor or endorse certain plans or types of plans should consider the withdrawal of such approval, sponsorship or endorsement whenever such plan or program persists in false, misleading, or deceptive advertising or sales methods.

7. Physicians be ever mindful of their moral responsibility for charging fees based upon the intrinsic value of services rendered since the existence of insurance should alleviate the economic burden for the individual and should not result in an increase in the customary or reasonable charge.

8. Although encouraging progress is being made in the extension and improvement of insurance available for the protection of the aged, the

impaired person and those living in remote areas, the American Medical Association, constituent associations and component societies should continue to cooperate fully with insurers in their efforts to insure persons with special problems of coverage.

9. All constituent associations and component societies maintain (to the extent not covered specifically under recommendation #2 above) active committees to meet with representatives of insurers and hospitals for consultation and the exchange of information on problems of mutual concern, the solution of which is in the public interest.

"King Bill" Defeated

The Ohio Senate on the night of July 8 decisively defeated Sub. Senate Bill 413, the "King Bill," which would have compelled hospitals to provide staff privileges for any licensed physician who is a veteran of World War II or the Korean Conflict.

Sponsored by Sen. Frank W. King of Toledo, majority floor leader of the Senate, the measure was strongly opposed by the Ohio State Medical Association and the Ohio Hospital Association.

The bill received only nine favorable votes. It needed 17 to pass the Senate. Those who voted against the bill were: Senators William Baker, Montgomery County; Arthur Blake, Belmont; John J. Corrigan, Cuyahoga; William H. Deddens, Hamilton; Lowell Fess, Greene; Tennyson Guyer, Hancock; Fred L. Hoffman, Hamilton; C. Stanley Mechem, Athens; Ray T. Miller, Jr., Cuyahoga; Tom V. Moorehead, Muskingum.

Charles A. Mosher, Lorain; Oliver Ocasek, Summit; Thomas F. O'Shaughnessy, Franklin; Julius J. Petrash, Cuyahoga; J. Sherman Porter, Gallia; Gordon Renner, Hamilton; Harry E. Schwall, Fulton; Robert R. Shaw, Franklin; J. E. Simpson, Hardin; and Theodore M. Gray, Miami.

Senators who abstained from voting — the equivalent of a "no" vote were: Anthony O. Calabrese, Cuyahoga; Danny D. Johnson, Tuscarawas; Ross Pepple, Allen; and Eugene J. Sawicki, Cuyahoga.

The nine Senators who voted for the bill were: Edward H. Dell, Butler; Charles J. Carney, Mahoning; Milton E. Cox, Lake; Fred Harter, Summit; Frank W. King, Lucas; Stephen R. Olenick, Mahoning; John C. Smith, Montgomery; Frank J. Svoboda, Cuyahoga; and Ed Witmer, Stark.

The 103rd Ohio General Assembly was still in session as this issue of *The Journal* went to press.

Following adjournment, a roundup of the action of the legislature on medical-health measures will be published in a later issue.

Present Policy of OSMA on Ethical Status of Physicians Participating in Any Third-Party Medical Care Plan

On December 15, 1957, The Council of the Ohio State Medical Association adopted a statement of policy with regard to the ethical status of members participating in any third-party medical care plan. The conclusions of such policy statement, which prevails at this time, were as follows:

"After a very careful review and consideration of the foregoing pronouncements of the American Medical Association and of this Association, The Council of the Ohio State Medical Association, for the guidance of individual members and of the component county medical societies, presents the following conclusions and recommendations with regard to the status of members of the Association participating in third-party medical care plans:

"1. The Ohio State Medical Association condemns and opposes any medical care plan which requires participating physicians to violate the Principles of Medical Ethics of the AMA in order for such physicians to comply with the rules and regulations governing such plan.

"2. The voluntary participation by a physician-member of this Association, or of any component society of this Association in a third-party medical care plan under conditions and circumstances which require, or result in, practices that are proscribed by the Principles of Medical Ethics of the AMA, as interpreted by the Judicial Council of the AMA, subjects such physician-member to disciplinary action by such component medical society. More specifically, any conduct or action on the part of the physician in connection with his participation in the third-party medical care plan which involves the sale or disposal of the physician's services under terms or conditions which:

"(a) Permit exploitation of his services for the financial profit of the third party; (b) Tend to interfere with or impair the free and complete exercise of his judgment and skill; (c) Tend to cause a deterioration of the quality of medical care in the community; (d) Involve solicitation of patients by the physician, directly or indirectly, or involve his consent to, or acquiescence in, solicitation of patients by others for or on behalf of the physician; or (e) Deny to the members of the community in which the physician practices a reasonable degree of free choice of a physician or physicians, would constitute a violation of the principles of Medical Ethics and subject him to disciplinary action by such component medical society.

"3. Sections 5 and 6 of the 1957 edition of the Principles of Medical Ethics of the AMA, as interpreted by the Judicial Council of the AMA, offer appropriate tests for the determination of the ethical or unethical conduct of a physician-member in connection with his participation in a third-party medical care plan.

"4. The Principles of Medical Ethics of the American Medical Association are broad enough and fundamental enough to cover any situation which may arise warranting disciplinary action on the part of a component county medical society against a member participating in a third-party medical care plan under conditions and circumstances which cause him to engage in unethical practices.

"5. As the Judicial Council of the American Medical Association once declared: 'the remedy for the evils associated with contract practice resides in the county society' and 'each case must be judged on its own merits after all the facts pertaining thereto are known.'

"6. The Bylaws of the component county medical societies affiliated with the Ohio State Medical Association, and the Bylaws of the Ohio State Medical Association itself, provide effective ways and means for disciplinary action against members guilty of violation of any of the provisions of the Principles of Medical Ethics of the American Medical Association. Any such disciplinary action as the facts may warrant should be initiated by component county medical societies in conformity with their Bylaws."

Ohio's New Medical Care Plan Law . . .

Enabling Act, Sponsored and Actively Supported By Unions, Farm Bureau
Effective October 1; Can Be Used to Organize Closed-Panel Type Programs

OHIO'S second enabling act authorizing corporations not for profit to establish and operate a pre-paid health care plan will become effective October 1.

Amended Substitute Senate Bill 461 was signed by Governor DiSalle on July 2 having completed its journey through the Ohio General Assembly on June 23.

Ohio's first enabling act on this subject was enacted by the General Assembly in 1941. It was known as House Bill 51 and was actively sponsored by the Ohio State Medical Association. It provides that the control of any plan initiated under the act shall be in the hands of the medical profession; that any such plan must have the active support of at least 51 per cent of the physicians practicing in the area in which the plan operates; that all physicians in the area may become participating physicians; and that subscribers shall have free choice of physician among the participating physicians.

At present there are no medical care plans operating under the enabling act of 1941, primarily because there has been no necessity due to the popularity and growth of the Blue Cross and Blue Shield (Ohio Medical Indemnity, Inc.) plans in the state.

Supported by Labor-Farm Bureau

Am. Sub. Senate Bill 461, enacted by the 1959 General Assembly by a vote of 30 to 1 in the Senate and 101 to 11 in the House, was sponsored by Senator Charles J. Carney, Youngstown, a staff representative of the United Steel Workers Union. It had the active support of the Ohio AFL-CIO, United Mine Workers Union, and the Ohio Farm Bureau Federation.

No Free-Choice Guarantee

The Carney Act makes no provision for control by the medical profession of any health care plan which may be set up under it. A plan organized under it may be a so-called closed-panel type plan as it does not contain a provision guaranteeing subscribers the free choice of physician. At the same time, there is nothing in the Act which would prohibit the plan from permitting subscribers to have free choice of physician. Efforts made by the Ohio State Medical Association to have a mandatory free-choice amendment inserted in the bill were unsuccessful.

The Carney Bill contains many safeguards similar to those of House Bill 51, enacted in 1941, but not all of the rigid provisions of the earlier measure.

Supporters Listed

Among the witnesses who testified for the bill at hearings in both the Senate and in the House was Dean A. Clark, M. D., Boston, director of the Massachusetts General Hospital; one of the founders of the Group Health Insurance Plan of Greater New York (HIP); and an official of the Group Health Federation of America—known as an ardent supporter of the group closed-panel type of medical plans.

A folder distributed by the proponents to members of the General Assembly, asking support for Senate Bill 461, was produced by the "Ohio Citizens for Voluntary Health Plans" and carried the following names:

Mrs. Gene Nielson, former president, Columbus League of Women Voters; S. O. Freedlander, M. D., Cleveland; Douglas R. Stanfield, executive vice-president, Ohio Farm Bureau Federation, Columbus; Elmer Cope, secretary-treasurer, Ohio AFL-CIO, Columbus; Miss Elizabeth Magee, Ohio Consumers' League, Cleveland; Ralph Perk, member, City Council, Cleveland; Ronald Owens, secretary-treasurer, UMW District 6, Columbus; Herman Schnurer, professor of French, Antioch College, Yellow Springs; Professor Carl Nielsen, professor of physics, Ohio State University, Columbus; Reverend Robert J. O'Brien, First Unitarian Church, Cincinnati; Jean Pilcher, M. D., Cleveland.

Arguments of Proponents

Some of the arguments advanced in favor of the bill which appeared in the pamphlet were: "It will enable the people of Ohio to organize—in cooperation with our doctors—medical care plans to meet all our needs. It will do this without interfering in any way with existing Blue Cross or Blue Shield or other medical insurance plans. It will help relieve the doctor shortage in small towns by allowing rural areas to join hands in forming health programs that will attract and support the doctors they need. By encouraging group medical practice under which doctors work cooperatively together, it will promote the highest standards of medical care in Ohio. It will make it possible to bring comprehensive high quality medical care within the reach of people who other-

wise do not receive such care. It will enable consumer, professional, trade unions and other groups to contract for their medical needs with health personnel on mutually agreeable terms. It gives the citizens of Ohio the right to have a voice in how their medical care will be financed."

Cited Closed-Panel Plans

In other material distributed by the proponents, the statement is made that the following states "either have established laws to regulate the development of such plans or have no law preventing the adoption of such programs": Connecticut, Maryland, North Carolina, Oregon, Washington, Illinois, Massachusetts, New York, Wisconsin, Texas, Delaware, Indiana, Missouri and Nebraska.

The following comment appearing in the proponents' pamphlet offers evidence that spokesmen for the measure were advocates of closed-panel type medical care plans:

"The two largest examples of programs in other states are the Health Insurance Plan of Greater New York and the Kaiser Foundation on the West coast which together cover over 1,250,000 people.

"There are many smaller programs in many other states including Group Health of Puget Sound, Seattle, Washington, Group Health, Washington, D. C.; Labor Health Institute, St. Louis, Missouri.

"These programs generally organized around groups of doctors offer comprehensive medical care for a single monthly amount.

"A subscriber and his family are entitled to whatever services are needed and covered in the contract. Usually doctors' services in the home, office, and hospital are covered along with hospital care and emphasis is given to the prevention of illness and health maintenance."

The purposes of the act are enumerated in Section 1 of Am. Sub. Senate Bill 461 which reads in part as follows:

"Notwithstanding any contrary provisions of Chapters 1737, and 1739, (Medical Care Corporations Act of 1941) and 1739 (Blue Cross Enabling Act of 1939) of the Revised Code, corporations not for profit organized under the laws of this state, upon compliance with Chapter 1702 (General Corporation Act) of the Revised Code, may establish, maintain, and operate a voluntary nonprofit health care plan by which professional and hospital services are provided, at the expense of such corporation, to such persons who become subscribers to such plan under contracts which entitle the subscribers to certain professional and hospital services, and to certain appliances and supplies incidental to such care. Such professional personnel and

hospitals shall, as may be required by law, be duly licensed in this state. Contracts with such professional personnel and hospitals for their services may be upon terms mutually agreeable as between them and the corporation. "Hospitals" may include convalescent and nursing home facilities. Such corporations may offer dental services to individuals or families who are subscribers to other services offered by such corporations.

Must Be Service Type Plan

The Act provides for service-type plans as Section 2 states that no contract described in the Act shall provide for the payment of any cash or other material benefit to a subscriber of a voluntary nonprofit health care plan, except in the case of a subscriber who secures emergency care from a physician or dentist outside the territorial limits of the plan.

The board of trustees of any corporation holding a certificate of authority or license from the superintendent of insurance, as required by the Act, "shall have non-physician and non-dentist representation," the Act states, adding that such board shall be elected by the subscribers and shall serve without compensation, except for necessary expenses.

Information Required

Before it may issue any contract or certificate to a subscriber, a corporation must obtain a certificate of authority or license from the superintendent of insurance. To get a certificate, a corporation must provide the following information:

- A copy of the corporation's articles of incorporation, and of any amendments thereto, certified by the secretary of state, which shall define with reasonable certainty the territorial boundaries within which such corporation proposes to operate its plan, and which shall state the location of the principal office;
- A list of names and residence addresses of all officers and the trustees of the corporation;
- A description of the health care plan which the corporation proposes to operate, together with the forms of all contracts or certificates which it proposes to issue under such plan;
- A statement of the assets and liabilities of the corporation.

Evidence Necessary

The Act states the superintendent of insurance shall issue a certificate of authority or license upon being satisfied:

- That the corporation proposes to establish and operate a bona fide nonprofit health care plan;
- That the proposed contracts and the pro-

posed rates between the corporation and the subscribers are fair and reasonable;

- That the proposed plan is established upon a sound financial and actuarial basis, in view of the experience of nonprofit health care plans already in existence.

Must Get Permission

There is a provision stating if a medical care plan corporation desires to amend any contract with its subscribers or desires to change any rate charged, a copy of the form of such amendment of any contract or the change of any rate shall be filed with the Superintendent of Insurance and shall not be effective until the expiration of 90 days after the filing, unless he shall sooner give to such corporation his written approval. The provision also says if the Superintendent is not satisfied within such 90-day period, that any such change or amendment of either the contract or the rate is lawful, fair and reasonable, he shall notify the corporation and it would be unlawful for the corporation to make effective any change or amendment.

Emergency Cases Covered

One section of the act provides that the plan shall not be operated outside the described territorial boundaries and that subscribers must be residents of that area. It does provide, however, that a subscriber who, in case of emergency, is treated by a physician not residing or practicing within the territorial area, shall be reimbursed in cash.

The medical care corporation must file an annual report with the Superintendent of Insurance which report shall include the following: financial statement, list of officers and trustees and amounts paid to them for expenses; number of subscribers' contracts issued and outstanding; number of physicians and dentists which have agreements with the corporation and the qualifications of each; and the number and type of services covered under the contract provided during the year.

The act provides that the superintendent of insurance may make an examination of the affairs of the corporation and may hold public hearings in connection with such investigations.

Certificate of the corporation may be revoked by the superintendent of insurance "if it appears to him that any of the following situations exist":

Reasons For Revocation

- The corporation is operating in contravention of its articles of incorporation or any amendments thereto, of its code of regulations and bylaws, or of its health care plan;
- The corporation is unable to fulfill its

obligations under outstanding contracts or certificates which it has issued to subscribers;

- The corporation has failed to comply with the Enabling Act;

- The corporation is not operating a bona fide non-profit health care plan;

- The existing contracts and the rates between the corporation and the subscribers are not fair and reasonable;

- The plan is not being operated upon a sound financial and actuarial basis, in view of the experience of non-profit health care plans already in existence.

Miscellaneous Provisions

The act provides that the corporation may accept from governmental agencies and from private agencies, corporations, associations, groups or individuals, payments covering all or any part of the premiums charged subscribers.

Subscribers must be given, at least annually, a complete description of the services available to them and information as to where and how the services may be secured.

One section states that participating physicians and dentists "shall name representative who may attend meetings of the trustees."

There is a prohibition against use of the words "insurance," "casualty," "surety," "mutual," or similar wording, in the name of the corporation or in contracts issued by it.

The corporation must maintain an unearned premium reserve "as provided by law" and may invest its reserves only in securities permitted by the laws of Ohio for the investment of capital surplus and accumulations of life insurance companies.

The penalty section provides for fines ranging from \$50 to \$1,000 for the first offense and \$100 to \$1,000 or imprisonment of not less than 30 days nor more than three years, or both, for subsequent offenses.

Dr. Jay Jacoby To Join Marquette Faculty

Dr. Jay Jacoby, Columbus, has resigned as professor of anesthesiology and chairman of the Department of Anesthesiology, Ohio State University College of Medicine, to accept a similar appointment at the Marquette University School of Medicine, Milwaukee.

Dr. Jacoby, who has been at Ohio State 12 years, will assume his new position about Sept. 1. He was a member of three OSMA committees: Committee on Scientific Work, Committee on Maternal Health, and Subcommittee on Workmen's Compensation.

Collective Bargaining and Health Plans ...

Effect of Labor-Management Agreements on Prepaid Medical-Hospital Programs and the Professions Described in Article by Harry Becker

IN this issue are found stories on the actions of the AMA House of Delegates on third-party medical care plans; free choice of physician; ethical matters relating to participation in third-party medical care plans; Ohio's new enabling act which was sponsored and supported by the AFL-CIO and Farm Bureau.

These are of particular interest at the moment because of the prominent publicity being given to the conflict going on between organized steel workers and management in an effort to work out a contract covering not only wages but fringe benefits such as medical-hospital services.

The effect of labor-management bargaining on prepaid medical and hospital care plans and on the medical profession and hospitals has become more and more significant each time a new contract is signed by a group of workers and their employer. These situations will become increasingly significant.

Becker Tells Why

Just how significant and what pressures are generated on plans, professions and institutions by these economic factors are emphasized in an article, "Changing Scene In Health Care Economics," published in the May 15, 1959, issue of *The New York State Medical Journal*.

The article was written by Harry Becker, director, Program Planning for the Blue Cross Association; formerly a US Public Health Service employee; at one time connected with the UAW-CIO Social Security Department and a member of the former Commission on Financing Health Care of the American Hospital Association.

The following excerpts from Becker's article describe the impact of collective bargaining on health care plans and health services:

Financing Problem

"An interesting facet of the general problem of financing a comprehensive level of health benefits, and one frequently not understood, is the effect that labor-management bargaining exerts on the availability of funds for health care and ultimately on patterns for organization of health services. Today a very high percentage of all

hospital care for the gainfully employed is financed from prepayment funds.

"The adequacy of financing for all elements of health care, such as hospital and surgical care, is related to the adequacy of prepayment benefits. The level and scope of these prepayment benefits are established by labor-management negotiations in what are called pattern-setting situations—that is, in such lead companies as General Motors, Ford Motor Company, U. S. Steel, and General Electric. What the corner drug store or the neighborhood grocery will do with respect to wages, working conditions, and employee benefits of various types is directly influenced by decisions made in key pattern-setting labor-management contracts.

Must Have Agreements

"Without legislative or regulatory action benefits cannot be increased or decreased for large pattern-setting employee groups except by agreement of the labor and management groups party to a collective bargaining contract. The prepayment agency cannot arbitrarily change benefits without first obtaining agreement from both labor and management. Management, of course, tends to resist any increases in its costs of health benefits which cannot be credited to management and labor as a collective bargaining gain. Consequently, approval for higher benefits is generally, for the pattern-setting situations, impossible to obtain except at the time the labor-management contract is open for bargaining.

Effects on Health Field

When labor sits down to bargain with the employer the decisions that are reached have a profound effect on the health field. Labor and management must first agree on the economic gain which is to be allocated to labor over the period of the contract. This gain reflects labor's share of increased productivity and other bargaining factors.

If the amount labor gains in a given negotiation, for the purpose of illustration, is 10 cents an hour for each year for the following three years, labor and management then proceed to determine how this ten cents will be allocated. Part will go to take-home pay and will be almost immedi-

ately spent for consumer wants. This increase in take-home pay is needed to buy the growing volume of goods and services our highly productive economy produces.

New Money Needed

But a part of this ten cents will go to items other than take-home pay. It will have to go to the cost of shortening the work week, for example, and to pay for supplemental unemployment benefits, to finance higher pension benefits, to meet the costs of a higher standard of retirement security, and for other similar items. And a part of this 10 cents must, of course, go to finance health service. With the costs of prepaid health care rising every year, and with the growing demands of employees for a broader scope of benefits together with higher benefits, about a penny an hour of new money has been needed every time labor and management bargain to keep pace with rising costs of health benefits.

Pressures Arise

Out of this economic situation stems much of the pressure on prepaid health care programs. Money gains are growing harder for labor to win because an inflation-conscious public insists that wage gains must be kept in closer relation to productivity increases. With the reduced economic gains being won by labor, which is probably a pattern that will prevail over the next few years, the pressure builds up for making new money gains stretch as far as possible. If collective bargaining allocations to health care could remain at a stable level of say 15 cents an hour for every hour employees work, new money won in bargaining would not have to go to health but could go to shorten the work week or for some other employee gain. But, as it is today, a goodly portion of new money gains must be allocated to health to keep pace with rising costs of prepaid protection. This means less for a shorter work week and other economic gains which labor feels are necessary.

Two Objectives

The result of this economic picture is exactly what we would expect. Both labor and management are today studying every feasible means of accomplishing two objectives where health benefits are concerned. They want to meet higher costs of care under prevailing benefit patterns and at the same time expand benefits to provide for more protection. These two objectives they want to accomplish in a manner which will provide the most for the least increase in cost. In the same sense the employer

wants to turn out a product which is the best he can produce for the least cost and the labor group wants to get the most in living standards out of the money available. And, this, I believe, is the major problem confronting us in the health field.

Coordinated Dermatology - Pharmacy Training Program Started

Designed to improve research, development, and teaching in these two fields, the department of dermatology in the College of Medicine, University of Cincinnati, and UC College of Pharmacy have begun a joint coordinated in-training program. The development was announced by Dr. Joseph F. Kowalewski, UC pharmacy dean, and Dr. Leon Goldman, department of dermatology chairman. Dr. J. Leon Lichtin, associate professor of pharmacy, is in charge of the program.

Dr. Lichtin is teaching a course to residents in dermatology, who go to the College of Pharmacy to learn about dermatological materia medica and pharmaceutical aspects of dermatology.

Cooperative research on more fundamental lines between the dermatology staff and the College of Pharmacy's graduate department is being developed under Dr. Lichtin's direction. Dr. Raymond R. Suskind, UC associate professor of industrial medicine and dermatology, and Dr. Ashton Welsh, UC assistant professor of dermatology and lecturer in pharmacotherapeutics, are giving lectures to students in pharmacy studying emulsions and ointments.

How To Re-Use Oxygen in Space Travel Is Subject of Study at Battelle

One more obstacle to manned space flights has become a laboratory challenge. Scientists at Battelle Memorial Institute in Columbus revealed that they have begun research to design and develop a practical system for freeing oxygen from carbon dioxide. Specialists at the research center are conducting the one-year study for Wright Air Development Center's Aero Medical Laboratory to assure future spacemen of an adequate supply of breathing oxygen.

Man's ability to extract oxygen from the air, use it, and then exhale it in the form of carbon dioxide is basic to his survival. This ability is also the crux of the problem now under study. On anticipated flights involving months or years, not enough oxygen can be carried aboard a space vehicle to sustain a man, unless a way is found to recover and re-use a large part of the oxygen.

Trustee-Staff Liaison . . .

Best Way to Accomplish Good Relationship Between Hospital Board and Medical Personnel is Through Joint Conference Committee, Report Says

THAT there should be the closest liaison between the governing body of a hospital and its medical staff cannot be successfully disputed. How should this be accomplished? The decision is one for local determination.

With the backing of the American Medical Association and American Hospital Association, the Joint Commission on Accreditation of Hospitals has stated that it believes the preferable way to establish liaison is through a Joint Conference Committee.

The Commission recently issued the following statement on this subject, which statement had the approval of the AMA and the AHA:

Cooperation and Organization

As the art and science of medicine have become more complex and more comprehensive, hospital services, of necessity, have followed suit in an effort to produce maximum results from medical progress. For this reason and because of the other joint and separate responsibilities which physicians and hospitals have in providing medical care and hospital services, organization and cooperation are essential.

These responsibilities cannot be discharged with maximum effectiveness without proper liaison between doctor and hospital, the doctor being represented in an organized manner by a medical staff and the hospital by its governing body and that body's designated representative, the administrator.

In addition to, but not in conflict with regularly established lines of authority and responsibility, there should be a common ground where these two groups can meet in order that there may be mutual understanding of each other's activities and problems. A suitable medium for this interchange of information and discussion is the Joint Conference Committee.

A "Must" In Each Hospital

This document seeks to encourage the development and to strengthen the role of the Joint Conference Committee of the Board of Trustees and medical staff. It urges the establishment of such Joint Conference Committees because it believes that they will bring to bear on major decisions which must be made in the hospital a full measure of broad experience, intelligence and responsibility.

Such a Committee should be a part of the organizational structure of every hospital. It should exist even where there is medical staff representation on the governing board. The representatives of this committee meet—not as representatives of the departments from which they were chosen—but as members of the committee as a whole in the interest of the patient, the physician, the hospital and the community.

The Joint Conference Committee is a discussion committee of the governing board and the medical staff. It has no intrinsic authority; if allowed to become an action group, its usefulness will at once be jeopardized.

Purposes

Its purposes, all directed toward better patient care, should be at least three:

a) Communications to keep board, staff and administration cognizant of pertinent actions taken or contemplated by one or the other. These should be reported to the committee even though they do not require action by more than one component of it. Open communications through the Joint Conference Committee will emphasize the importance of prior knowledge of all affected groups before action is instituted and will thus prevent misunderstanding.

b) Planning. Plans for growth and inevitable change in the hospital organization should be considered by this committee.

c) Problems. Issues which arise in the operation and affairs of the hospital affecting all parties should be brought to the committee for consideration.

Organization

While the Joint Conference Committee may be organized in any of several ways, the following, which is only a guide, is offered as an example:

(a) The Joint Conference Committee of the governing board and the medical staff should be composed of equal numbers of representatives elected or appointed by the governing board and the medical staff. The administrator should be an ex officio member of the committee.

(b) The chairman of the Joint Conference

Committee may be alternated between representatives of the governing board and of the staff.

(c) The Joint Conference Committee should meet at regular intervals no less frequently than four times per year, and should meet on call when necessary.

(d) The committee should feel free to invite to its meetings persons within or without the hospital who can contribute from their specialized knowledge or experience.

(e) A formal agenda should be prepared from suggestions of the members and submitted to all members of the committee in sufficient time before the meeting.

(f) Minutes should be kept by the secretary and should be maintained in the permanent records of the hospital.

(g) A resume of the minutes of the Joint Conference Committee should be presented at meetings of the governing board and at meetings of the medical staff.

All A. M. A. Dues-Paying Members Will Receive The Journal and a Specialty Journal

The House of Delegates of the American Medical Association at the Atlantic City meeting in June endorsed a new policy adopted by the Board of Trustees whereby all dues-paying members of the Association will receive *The Journal of the A. M. A.* and one of the AMA specialty journals as a dues-paying membership benefit. Dues-paying members may select any one of the 10 AMA specialty journals in the fields of internal medicine, surgery, ophthalmology, children's diseases, otolaryngology, pathology, dermatology, industrial health, neurology, or psychiatry.

Thus, in all, such members will receive as a benefit of membership an AMA specialty journal of their choice, *Today's Health*, *The AMA News*, and *The Journal*. Since the range of *The Journal* extends across the entire field of medicine, the House of Delegates and the trustees believe that all members of the Association should receive *The Journal* in addition to the specialty journal of their choice.

The dues-paying members who are not now receiving *The Journal* because they chose to receive a special journal will begin receiving *The Journal* within a few weeks. The 142,000 dues-paying members who already receive *The Journal* will receive an announcement asking them to choose one of the 10 scientific monthly journals, which will then be sent to them when their choice is made known to the Circulation and Records Department.

New Members of OSMA

The following are the names of the new members of the Ohio State Medical Association since May 14, 1959. The list shows the county in which they are affiliated, city in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

Allen County

Robert I. Zarzar, Lima

Belmont County

Joseph H. Nodurft,
Martins Ferry

Butler County

Janis Skrastins, Hamilton
Elmer M. Truman, Jr.,
Hamilton

Cuyahoga County

Robert L. Atkinson,
Cleveland
Issac Knoll, Cleveland
Elizabeth Korst-DeWitt,
Cleveland
John G. Margrett, Cleveland
Robert T. Murphy,
Cleveland
Frederick W. O'Brien, Jr.,
Cleveland
Richard A. Wiant, Cleveland

Erie County

Tibor A. Pollerman,
Sandusky

Franklin County

James F. Alexander,
Columbus
Basil V. Bisca, Columbus
James M. Carhart, Columbus
Carl R. Coleman, Columbus
Herndon P. Harding,
Columbus
Francis P. Kintz, Columbus
Allan R. Korb, Columbus
George M. Leiby, Columbus
Gerd Leopoldt, Columbus
Alan D. Randall, Columbus
Jack L. Stauff, Columbus

Guernsey County

Russell E. Leach,
Cambridge

Hamilton County

Chester E. Nameth,
Cincinnati

Jefferson County

John W. Metcalf, Jr.,
Worthington

Lorain County

Robert Paul Hardwig,
Lorain
Boyd N. Park, Elyria

Mahoning County

Annelies R. Dziadzka,
Youngstown

Marion County

Ralph Morton, Marion

Miami County

Ramen K. Das, Troy

Muskingum County

James S. New,
Zanesville

Richland County

A. R. Dedehayir,
Mansfield
Eugene Sherman,
Mansfield

Scioto County

Clyde O. Hurst,
Portsmouth

Summit County

H. Thomas Baumgardner,
Akron
Roy E. Bugay,
Barberton
James I. Farmer, Akron
Norman M. Glazer, Akron
William H. Holloway,
Akron
Michael V. MacInnis,
Akron
Peter Ogden, Barberton
Edward C. Schott, Akron

Medical Educators Tell How World Conference Affects Average Person

Pooling of international efforts toward improved health will highlight the Second World Conference on Medical Education which will be held in Chicago, Aug. 20 to Sept. 4. Medical educators from 50 different countries will take part in this meeting which is being sponsored by the World Medical Association, World Health Organization, Council for International Organizations of Medical Sciences, and International Association of Universities.

Between 1,500 and 2,000 persons from all over the world will attend the conference and there will be 125 speakers.

General Practice Assembly . . .

**Ninth Annual Scientific Assembly of Ohio Academy of General Practice
Will Be Held at Veterans Memorial Building, Columbus, September 16-17**

THE OHIO Academy of General Practice will hold its Ninth Annual Scientific Assembly in the Veterans Memorial Building, Columbus on Wednesday and Thursday, September 16 and 17. The program is acceptable for 10 hours Category I Credit for AAGP members. The program has been announced as follows:

Wednesday, September 16

9:00 A.M.—**Specific Problems Pertaining to the Practice of Industrial Medicine**—panel. Joseph A. Solomayer, M.D., Cleveland, Moderator

Occupational Dermatoses—Donald Birmingham, M.D., Cincinnati

Common Psychiatric Diagnoses Encountered in Occupational Medical Practice—Donald Ross, M.D., Cincinnati

The Control of Some of the Major Health Hazards in Ohio — Thomas F. Mancuso, M.D., Columbus

Medicolegal Aspects of Industrial Practice—Mr. William C. Hartman, Attorney, Cleveland

Question and Answer Period

10:30—Visit Exhibits

11:15—**Hepatitis**—Leon Schiff, M.D., Cincinnati

12:00—Lunch and Visit Exhibits

1:00 P.M.—**Office Suturing** — John Kelleher, M.D., Toledo

1:30—**Common Surgical Emergencies**—A. Lee Lichtman, M.D., New York City

2:00—**When to Refer the Cardiac for Surgery**—Bernard L. Brofman, M.D., Cleveland

2:30—Visit Exhibits

3:15—**Hematuria in Benign Conditions**—Edwin P. Alyea, M.D., Durham, North Carolina

4:00—**Chemotherapy of Cancer**—John R. Keys, M.D., Dayton

6:00—Social Hour and Dinner-Dance. **Why We Laugh**—Wm. Craig, Ph.D., Wooster

Thursday, September 17

9:00 A.M.—**Examination of the Back**—Jos. T. Leach, M.D., Columbus

9:30—**GP's Approach to the Parkinsonian Patient**—Kenneth H. Abbott, M.D., Los Angeles

10:00—**The Allergic Patient, his Problems, Office Diagnosis and Treatment**—John Burger, M.D., Birmingham, Michigan

10:30—Visit Exhibits

11:15—**Anticoagulant Therapy**—Gordon Todd, M.D., Toledo

12:00—Lunch and Visit Exhibits

1:00 P.M.—**Diagnosis, Management and Prevention of Rheumatic Fever**—Don M. Hosier, M.D., Columbus

1:30—**New Concepts in Neonatal Jaundice**—Warren E. Wheeler, M.D., Columbus

2:00—**Care of Preschool Child**—Thomas E. Shaffer, M.D., Columbus

2:30—Visit Exhibits

3:15—**Diuretics**—Kathryn Dustan, M.D., Cleveland

3:45—**Management of Frustration in Everyday Practice**—Victor Szyrnski, M.D., Ottawa, Canada

Ohioans on Program of Interstate Postgraduate Medical Group

Several Ohio physicians are on the coming program of the Interstate Postgraduate Medical Association. The 44th scientific assembly will be held at the Palmer House, Chicago, November 2-5.

Dr. Irvine H. Page, Cleveland, will speak on the subject, "The Newer Antihypertensive Drugs."

Dr. W. J. Kolff, Cleveland, will participate in a panel discussion on "Renal Failure."

Dr. Geo. J. Hamwi, Columbus, will discuss the subject, "New Concepts in the Treatment of Diabetes," and participate in a panel on "Non-Toxic Goiter."

Dr. George Crile, Jr., Cleveland, will participate in a panel discussion on "Non-Toxic Goiter."

Dr. Robert M. Zollinger, Columbus, will speak on the subject, "Indications for Splenectomy," and take part in a panel discussion on "Evaluation of the Acute Abdomen."

Dr. Stanhope Bayne-Jones, technical director of research, Army Medical Research and Development, was awarded an honorary degree in June by Western Reserve University, Cleveland.

Forand Bill Hearings . . .

OSMA Statement Is Among Those Presented in Opposing Further Federal Encroachment into the Medical Care Field; Flemming Opposes Passage

FIVE FULL DAYS of hearings on the Forand Bill by the House Ways and Means Committee the week of July 12 were led off with a flat statement of opposition by the Secretary of Health, Education and Welfare.

Secretary Arthur E. Flemming told the committee the bill, HR 4700, was almost a certainty to deal a death blow to the voluntary health insurance field. He called for every possible effort to develop a plan to strengthen voluntary hospital insurance for the aged. He told the committee that this was the Administration's position.

AMA Leads Opposition

Speaking for the AMA, Dr. Leonard Larson, Chairman of the Board of Trustees, told the committee that progress already is being made toward solution of the problem, that 60 per cent of the senior citizens who need and want health insurance will have it by the end of 1960, 75 per cent by 1965 and 90 per cent by 1970.

He said the fine job being done by private insurance and prepayment plans would be nullified by passage of the bill.

Also speaking for AMA, Dr. Frederick C. Swartz, chairman of its Committee on Aging, said passage of the bill would result in overcrowding of hospitals, curb community incentive to support hospitals, discourage families from caring for their own, restrict free choice of physician and hospitals, severely handicap physician-patient relationship, destroy individual approach to patient care, and would attempt to chart a health program without knowledge of the problem's dimensions.

A statement by OSMA in opposition to the bill was presented to the committee through Ohio Congressman Jackson E. Betts, Findlay, a member of the Ways and Means Committee.

Opponents, Proponents

Other organizations appearing in opposition to HR 4700 included:

U. S. Chamber of Commerce; North Carolina, California, Iowa, Florida, Texas, Illinois, Tennessee, Pennsylvania, Virginia, Mississippi, Kentucky and New York Medical Associations; American Hospital Association.

American Academy of General Practice, College of American Pathologists, American Pharmaceutical and Iowa Pharmaceutical Associations, National Blue Cross, Iowa Medical Service, Health Insurance and Life Insurance Associations of America, Commerce and Industry Association of New York, International Association of Accident and Health Underwriters.

American Society of Internal Medicine, American Farm Bureau Association, American Nursing Home Association, and Council of State Chambers of Commerce.

Speaking in support of HR 4700 were Walter Reuther and Nelson Cruickshank, for the AFL-CIO, Philadelphia Hospital Council, National Farmers Union, National Association of Social Workers, The Physicians Forum, Inc., Council of Golden Ring Clubs, Civil Service Council, American Federation of State, County and Municipal Employes, Group Health Association of St. Paul, Minn., American Public Welfare Association.

American Nurses Association, National Consumers League, Social Security Clubs of America, Douglas J. Brown, Princeton University's Dean of the Faculty; Americans for Democratic Action, Health Insurance Plan of Greater New York, Group Health Association of America, Tennessee State Labor Council, Massachusetts State Commissioner of Public Welfare, International Ladies' Garment Workers' Union.

Further action on the Forand bill during the current session of Congress is not anticipated. However, it is expected that those interests supporting the measure will launch a drive for its passage when Congress reconvenes in January.

Says Statement Erroneous

James L. Young, administrator, Bureau of Workmen's Compensation, has informed *The Journal* that certain information given to some Ohio employers by an organization engaged in making gas and dust surveys for industry is erroneous. A letter sent by the organization infers that an employer might be assessed 50 per cent of an occupational disease claim allowed by the Bureau of Workmen's Compensation for violation of a specific safety requirement of the Workmen's Compensation Law. Mr. Young points out that the regulations governing safety procedures do not apply to matters of occupational diseases.

Facts on Forand Bill . . .

Many Questions About Controversial Measure Pending in Congress Are Answered in Pamphlet Just Produced by American Medical Association

UNDOUBTEDLY, most Ohio physicians have heard about the Forand Bill. However, it's quite likely many of them are not familiar with the detailed provisions of the 1959 model.

The American Medical Association has just produced a concise factual pamphlet on HR 4700, the Forand Bill, in question and answer form. To bring readers up to date, *The Journal* is reproducing herewith the text of this new pamphlet, copies of which may be obtained in quantities from the AMA Chicago Office:

Q. What is the Forand bill?

A. The Forand bill is a proposal to amend the Social Security Act to provide for the federal purchase of certain health care services for social security beneficiaries. Introduced in the 86th Congress by Rep. A. J. Forand of Rhode Island, H. R. 4700 is now before the House Ways and Means Committee, of which Mr. Forand is second-ranking member. Under the bill's terms, some 16 million persons eligible for social security benefits—mostly those over 65—would be entitled to receive hospital, surgical and nursing home treatment under a government-run program. The government would contract to pay hospitals, nursing homes, physicians and dentists for the services they would provide.

Q. What would it cost?

A. Authoritative estimates—based upon the 16 million persons who are eligible for social security benefits at the present time—are in the neighborhood of \$2 billion for the first and second years. When it is considered that the number of persons eligible for social security benefits will increase steadily in the years ahead, it becomes obvious that the cost of the program will rise accordingly, year after year. The expense would be staggeringly high, and could jeopardize the retirement security of millions who depend on social security for their basic retirement needs.

Q. Who would pay the bill?

A. Everyone who pays social security taxes. Already those taxes are scheduled to reach 9 per cent of payroll—up to \$4800—in the years ahead. The Forand bill would send them higher. The increases it calls for, on top of those already sched-

uled by law, would mean a smaller paycheck for everyone under social security.

Q. Would this raise in the social security tax cover the cost of the program?

A. Probably not. Historically, cost estimates for compulsory health insurance—for any segment of the public—invariably fall way short of reality. This factor, plus the constant increase in our older population, makes it improbable that the Forand bill estimates would prove an exception to the general rule.

Q. What are the basic faults of the Forand bill?

A. There are many of them besides high cost. Here are a few: (1) Care for the older citizen calls for a cooperative attack on the problem by nurses, doctors, hospitals, social workers, insurance companies, community leaders. It requires flexibility of medical approach and technique—not the rigidity inherent in government-controlled programs. The Forand bill is simply bad medicine. (2) It is a political approach to a health problem developed by non-medical people. (3) A nationalized program of this sort would weaken the patient-physician relationship. (4) Political abuses and administrative waste would be predictable.

Q. How would the vast majority of Americans—those who aren't receiving social security payments—be affected by passage of the Forand bill?

A. Adversely. Overuse of hospitals by social security claimants—that is, hospitalization not warranted by medical necessity—is certain to occur. The effect of this would be to limit the number of beds available for the acutely ill of all ages within all communities. So-called “free” hospitalization on any extensive scale—“free” only to the extent that the taxpayers pay for it—could create a dangerous overcrowding of available space. The record of similar legislation in other countries bears this out unarguably.

Q. Would the patient be free to choose his own physicians, hospital or nursing home?

A. No. Although at first glance the bill appears to guarantee the patient's right to choose any hospital, surgeon or nursing home he wants, this apparent freedom of choice is deceptively limited. For the patient is required to select a

hospital, nursing home or physician under contract to the federal government. In emergencies only could the patient choose a surgeon not participating in the plan.

Q. What hospital and nursing home services would be provided under the Forand bill?

A. The measure provides a combined total of 120 days hospital and nursing home care each year, but with a maximum of 60 days hospitalization. However, before a person can receive nursing home care, he must be transferred there from a hospital for further treatment of the same illness. Care would not be authorized in a mental or tuberculosis hospital.

Q. Who would set fees for physicians, and charges for hospitals and nursing homes?

A. An agency of the federal government.

Q. Who would administer the program and stipulate the type of care to be provided?

A. An agency of the federal government.

Q. What effect would the Forand bill have on voluntary health insurance?

A. It would undermine voluntary health insurance and gradually replace it, because few people will be willing or able to carry both government and private plans. Yet the health insurance industry has proved its ability to handle the extensive needs of our growing population. About 43 per cent of our over-65 citizens are now covered by health insurance. Much of this coverage has been achieved during the past five or six years. This rapid growth in voluntary insurance can be expected to continue so long as our senior citizens are free to choose—from an increasingly wide variety of policies—the sort of health coverage best suited to their individual needs. According to the Health Insurance Association of America, 75 per cent of our older people who need and want such protection will be covered by voluntary health insurance by 1965; and 90 per cent by 1970.

Q. Would the Forand bill help our sick but indigent older citizens?

A. No. Most of our indigent are not covered by the Social Security system. Hence they would receive no assistance under the Forand measure. They now receive the care they need through private, fraternal and religious organizations; and welfare programs paid for by federal, state and local governments.

Q. How reliable are the statistics on the health problems of the aged?

A. AMA has studied those presently available

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A standard vehicle identification card is available to physicians in order to facilitate movement of their cars during emergency conditions. Obtainable from the city or county director of civil defense, these cards are designed for use on all emergency vehicles.

According to information from the Ohio Adjutant General's office, a standard design is in use throughout Region 2 of the Office of Civil Defense Mobilization, which includes Ohio, Pennsylvania, West Virginia, Kentucky, Delaware, Virginia, Maryland and the District of Columbia. Cards differ from state to state in that the name of the state and the state seal is printed in the center.

and found them to be neither conclusive nor complete.

Q. How is it possible, then, to propose far-reaching legislation aimed at solving the health problems of the aged?

A. It isn't. It is neither practical nor sound planning. Any attempt to meet the challenge of a health program for the aged without more accurate knowledge of the problem's dimensions is akin to prescribing for the patient without first making a diagnosis.

Q. If the Forand bill were to become law, is it likely that compulsory health insurance would later be extended to include all segments of our population?

A. Yes. It is most likely. The bill's supporters have indicated they want to see government-regulated health care extended to everyone eventually. The next step, if the Forand bill established the precedent, would be to lower the age eligibility and broaden the field of coverage. This process could be expected to continue, session after session, until every American had been placed under a compulsory, government-run health insurance program. The important thing, as the bill's supporters see it, is to set the precedent.

Dr. Albert B. Sabin, professor of research pediatrics at the University of Cincinnati College of Medicine and fellow in the Children's Hospital Research Foundation, was awarded an honorary degree of doctor of science Wednesday morning, June 10 by New York University in its 127th annual commencement exercises.

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Ohio's New Immunization Law . . .

All School Children, Unless Their Parents File Written Objections, Must Provide Evidence of Immunization Against Polio, Smallpox and DPT

AMENDED HOUSE BILL 323, Ohio's new law to provide that all school children, unless their parents file written objection, must be immunized against polio, smallpox, diphtheria, whooping cough and tetanus in order to be admitted to school, became effective July 7, 1959, the day the bill was signed by Governor DiSalle as an emergency measure.

The text of the new law was sent by the OSMA Headquarters Office, July 9, to all county medical society presidents and secretaries with the following comment:

"Plans and procedures for carrying out the provisions of the act will have to be worked out in each county for the school districts of the county through conferences between representatives of the boards of education, boards of health, city and township officials and County medical society. There can be no stereotyped pattern. Procedures will have to vary, depending on local circumstances and local policies."

On July 15, Dr. Ralph E. Dwork, Ohio Director of Health, issued a memorandum to all local health commissioners on the subject of the new compulsory school immunization law. Copies were sent by OSMA to county medical society officers. Dr. Dwork's memorandum follows:

Health Directive

During the past week, the Governor signed into law a bill providing for the compulsory immunization of elementary and high school students in the State of Ohio against poliomyelitis, smallpox, diphtheria, whooping cough, and tetanus. Since this legislation was passed as an emergency measure it will affect students entering school this Fall. Beyond those previously available, no state-wide funds were provided to defray the cost of these procedures. Except for the emergency clause the applicable portions of this law are as follows:

The New Law

"No pupil shall be admitted, at the time of his initial entry of each school year, to an elementary or high school for which the state board of education prescribes minimum standards in accordance with the provisions of division D of section 3301.07 of the Revised Code, unless such pupil has presented written evidence, satisfactory to the person in charge of admission, that he has re-

ceived, or is in the process of receiving, immunization against poliomyelitis, smallpox, diphtheria, pertussis, and tetanus by such means of immunization as may be approved by the department of health pursuant to the powers granted by section 3701.13 of the Revised Code, or unless such pupil has presented a written statement of his parent or guardian objecting to the immunization of such pupil against poliomyelitis, smallpox, diphtheria, pertussis, and tetanus. The provisions of this section shall not limit or impair the right of a board of education of a city, exempted village or local school district to make and enforce rules or regulations to secure vaccination or immunization against poliomyelitis, smallpox, diphtheria, pertussis, and tetanus of the pupils under its jurisdiction.

"Boards of health, legislative authorities of municipal corporations, and boards of township trustees on application of the board of education of the district or proper authority of any school affected by this section, at the public expense, without delay, shall provide the means of immunization against poliomyelitis, smallpox, diphtheria, pertussis, and tetanus to such pupils as are not provided therewith by their parents or guardians."

Some Areas Already Covered

Some local boards of education already have established compulsory immunization against one or more of the diseases in question. The problem of implementing this law in such areas will be considerably less than those in which no previous steps had been taken. While it is expected that most of the children will be vaccinated privately, many will be left to the responsibilities of the local governmental authorities.

Although it is anticipated that other administrative problems will arise because of this law in the coming months, the first to be considered are the approved means of immunization as related to the State in general.

What Must Be Done

For the purpose of compliance with this law the following minimum immunizations are approved:

- (1) For all students, a single successful vaccination against smallpox.
- (2) For all students, basic immunization against



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poliomyelitis consisting of three injections of an acceptable killed poliomyelitis vaccine given in accordance with earlier recommendations on this subject.

In addition to (1) and (2)

(3) For students less than 8 years of age, a primary series of at least three vaccine injections resulting in basic immunization against diphtheria, whooping cough, and tetanus.

(4) For students 8 through 14 years of age, a primary series of at least two vaccine injections resulting in the basic immunization against diphtheria and tetanus; and

(5) For students more than 14 years of age, a primary series of at least two injections resulting in basic immunization against tetanus.

Exemption by Age Groups

The exemption of students of various age groups from the requirement of immunization against certain of these diseases is in accordance with accepted medical practice which weighs the danger of disease either to the private or the public health against possible untoward individual reactions resulting from the injection of vaccines:

(1) Vaccination against whooping cough is discontinued at about the 8th year because the danger to the individual has become minimal while reactions to the vaccine may be more severe with increasing age.

(2) Untoward side reactions following the injection of standard diphtheria toxoid occur with increasing frequency and severity as the age of the recipient increases.

Since basic immunization against diphtheria, whooping cough, and tetanus may be accomplished by several different types of vaccine it is not feasible to approve a single method for any or all of these immunizations.

For purposes of compliance with this law, it does not seem reasonable to require evidence of "booster" inoculations against these three diseases.

Additional Precautions

It is not the purpose of the Ohio Department of Health to limit immunization programs in schools or elsewhere solely to the level of compliance but to foster procedures which are in accord with good medical practice. Consequently, in addition to the above mentioned minimum means of immunization, programs which contain the following recommendations are advocated wherever practicable:

(1) Revaccination against smallpox every 4-5 years.

(2) "Booster" injection of poliomyelitis vac-

Special Accident Survey Set for Turnpike

Ohio physicians in the area of the Ohio Turnpike are requested by the Ohio State Medical Association to cooperate in a special turnpike accident injury survey which started August 1.

Conducted by the Cornell Automotive Crash Injury Research program of Cornell University, the study will be a part of a survey of the Ohio and Pennsylvania Turnpikes and the New York State Thruway. It is an extension of a current survey in Ohio being conducted by the Cornell facility in cooperation with OSMA and the State Highway Patrol.

Physicians who treat persons injured in Ohio Turnpike accidents will be handed by the investigating patrolman, a brief form for the physician to complete. On completion, it is to be mailed to Tom F. Lewis, M.D., Medical Coordinator, Crash Research Program, Mount Carmel Hospital, Columbus, Ohio. It and the patrolman's report then will be sent to Cornell for statistical analysis.

cine if in time it becomes evident that these are indicated.

(3) "Booster" injections of diphtheria, whooping cough, and tetanus vaccines given either in recognized combinations or separately, one year after the basic series of injections and every four years thereafter except (for reasons mentioned above) that "booster" injections against whooping cough should be discontinued at 8 years of age, and diphtheria "boosters" at 14 years of age (if only standard diphtheria toxoids are available for use.)

(4) Basic immunization may be initiated and "booster" injections continued against diphtheria beyond the 14th year if they can be accomplished by more suitable products such as the so-called "adult" diphtheria-tetanus toxoids or by any similar practical means wherein a smaller amount of diphtheria toxoid is contained in a single inoculation.

Further memoranda will be distributed in the near future on other aspects of this subject.

Infant feeding, with emphasis on protein, iron, calcium and phosphorus, will be the topic of an October 27 symposium sponsored by the American Medical Association's Council on Foods and Nutrition in cooperation with local groups.



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*Editorial: New England J. Med. 260:246 (Jan. 29) 1959

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Out of the Blue . . .

Another Article of Interest to OSMA Members Regarding Ohio's Blue Shield Plan Prepared by Dr. R. D. Dooley, OMI Physicians' Relations Director

By R. DEAN DOOLEY, M.D.

Director, Physicians' Relations Department, Ohio Medical Indemnity,
3770 N. High St., Columbus 14, Ohio

PERRY COMO usually closes his show with his letter box routine which consists merely of answering requests received by mail for song numbers. We are not trying to steal Como's stuff and this is in no sense a concert, but Ohio Medical Indemnity, Ohio's Blue Shield Plan, does receive letters—many letters.

Letters are intriguing whether they contain a request, express an opinion, pay a compliment or give a blast. We are happy to receive mail because it indicates an interest on the part of the writer and it shows that he is giving thought to problems affecting his patients, his colleagues and organized medicine.

We receive letters in which we are condemned because Blue Cross rejected a hospital claim. There are still physicians in Ohio who think Blue Cross and Blue Shield are one and the same. They make no attempt to differentiate between the two. Of course, we can be no direct help in answering questions relating to hospitalization. We can only refer the writer to the appropriate Blue Cross plan which causes delay and generally aggravates the irritation already annoying the complaining doctor.

Didn't Have Coverage

Some writers are critical because benefits are denied or are lower than they believe they should be. For instance, one physician wrote a scorching letter because his patient was hospitalized two weeks for a medical condition and we refused to pay a per diem payment for medical care. He, of course, was close to his patient, who doubtless was worthy and badly in need of the financial assistance the indemnity would have provided. Unfortunately, the patient did not have medical coverage in his contract. The Claims Department quite properly rejected the claim because they had no alternative.

Letters are received from physicians chastising us for requesting additional information on their patients' O. M. I. claim forms. We process 30,000 claims monthly and quite obviously, write letters only when absolutely necessary. In the vast ma-

jority of cases where additional data are requested, the information is needed to complete the claim. In many cases, the additional information results in larger payments to the subscriber. When you are tempted to lose your patience with us, please hesitate a moment and remember we are trying to do a good job for you and your patient. Rather than being irritated, take satisfaction from the fact that you are being given another opportunity to perform a worthwhile service for your patient.

Better Contract Available

Before writing to us to complain that the benefits of the Standard Contract, which contract was the first to be issued by OMI more than 10 years ago, are too low, remember this: Many groups of subscribers have not converted to the Preferred Contract—a newer and more liberal contract. Subscribers who have not done so should keep in mind that the only benefits to which they are entitled are the lower ones of the Standard Contract. They should think seriously of converting to the Preferred Contract. Physicians can be helpful in suggesting that they do so.

We are in no way critical of physicians who write us. On the contrary, we sincerely invite your letters whether they be critical or commendatory, because this gives us an opportunity to get a point across to you. Your letter to us presents an exciting challenge to make of you a warm and lasting friend.

West Va. EENT Society Elects

The West Virginia Academy of Ophthalmology and Otolaryngology meeting at the Greenbrier Hotel, White Sulphur Springs, in June, elected the following officers for the coming year:

President, Nime K. Joseph, M.D., Wheeling; President-elect, John A. B. Holt, M.D., Charleston; Vice-President, William K. Marple, M.D., Huntington; Secretary-Treasurer, Albert C. Esposito, M.D., Huntington; Director for Two Years, James T. Spencer, M.D., Charleston. The next meeting will be August 20-23, at the Greenbrier Hotel.



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A Study of Two Kinds of Medical Care Plans

In its June, 1959, statistical bulletin, *Progress in Health Services*, the Health Information Foundation published preliminary findings of a survey of two New York City plans, Group Health Insurance, Inc. (GHI), and the Health Insurance Plan of Greater New York (HIP). The study was made in cooperation with the National Opinion Research Center of the University of Chicago. Both plans cover physicians' services not only in the hospital but also in home and office; subscribers receive hospitalization benefits through their Blue Cross coverage.

The plans differ in their arrangements with physicians. GHI makes payments to doctors practicing out of their private offices, paying a fee for each service on the basis of a fee schedule. HIP, on the other hand, provides physicians' services in 31 group medical centers, paying these groups on a capitation basis.

Subscribers interviewed in the survey were drawn from three New York unions, members of which were free to join either plan under collective bargaining agreements.

Both HIP and GHI covered about a third of subscribers' total expenses for doctors, hospitals, dentists, drugs, and other medical items. This proportion, the Foundation noted, was higher than the proportion of total costs met under the more usual health insurance plan, which covers only in-hospital services.

Members of the two plans reported quite similar experiences regarding utilization and costs of services outside the hospital. But they "differed markedly," the Foundation said, in average utilization and costs of hospital care and surgery, and in their attitudes toward their plan.

HIP met 80 per cent of enrollees' costs for all physicians' services, against 59 per cent for GHI. GHI subscribers used more hospital care and surgery than did HIP members—11.0 hospital admissions per 100 persons against 6.3, and 7.6 hospital surgical procedures per 100 persons against 4.3.

Where members' attitudes were concerned, the Foundation said, "GHI enrollees were more satisfied with both the plan and its physicians." Ninety per cent of the GHI members were "entirely" or "fairly well" satisfied with their plan, against 79 per cent of the HIP members.

The U. S. Public Health Service's Cancer Chemotherapy National Service Center will hold a two-day conference on clinical anticancer drug research in Washington, D. C., on November 11-12, 1959.

Nurses Association Has Active Counseling - Placement Service

One of the programs of the Ohio State Nurses Association is the Professional Counseling and Placement Service. It assists members in finding employment and also aids employers in filling positions at no cost.

After a position is listed with the association, it refers qualified nurses. If they are actively interested they request a copy of their professional biography to be sent to the physician. This biography is a summary of education and experience including evaluations of performance in previous employment. Final arrangements remain between the nurse and employer.

Will Help Edit Nuclear Journal

Dr. Eugene L. Saenger, associate clinical professor of radiology in the University of Cincinnati College of Medicine, has been appointed an associate editor of the *Journal of Nuclear Medicine*, a new quarterly which is the official publication of the Society of Nuclear Medicine.

At the request of the Atomic Energy Commission, Dr. Saenger is preparing what will be the nation's first handbook for physicians who must treat victims of serious radiation or nuclear accidents.



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References: 1. Finkelstein, M., et al.: J. Pharmacol. & Exper. Therap. 125:330 (April) 1959. 2. McHardy, G., et al.: Postgrad. Med., in press. 3. Winkelstein, A.: Amer. J. Gastroenterol., in press. 4. Finkelstein, M., et al.: Presented at Fall Meeting, Amer. Soc. Pharmacol. & Exper. Therap., 1958. 5. Leming, B.: Clin. Med. 6:423 (March) 1959.

*Trademark

New Internship Proposed . . .

Recommendation for Two-Year Hospital Training Period For Physicians Who Plan to Enter Family Practice Approved; New Program Described

HIGH in importance among the actions taken by the AMA House of Delegates at its 1959 session in Atlantic City was that:

1. Urging the establishment of a formal hospital training of at least two years for physicians intending to enter "family practice";

2. Setting up of a working definition of the term "family practice";

3. Spelling out in some detail the requirements of and kinds of instruction which should be given in the basic two-year minimal program.

These actions came through adoption of recommendations made by a special Committee on Preparation for General Practice, created by the AMA Board of Trustees at the request of the House of Delegates in November, 1956. The special committee consisted of representatives of the Council on Medical Education and Hospitals, American Academy of General Practice, Association of American Medical Colleges, and of the various specialty areas.

Following are pertinent excerpts from the report of the committee which was approved by the House of Delegates:

General Considerations

"The Committee undertook its assignment in full recognition of the need for a long range objective study regarding what basic educational background would best prepare future physicians for general practice. This immediately raised questions about the future nature of such practice in the light of the needs of the people as well as the changing dimensions of medical knowledge.

"After careful thought and study of pertinent data, the Committee has concluded that the marked trend toward what is called full time specialty practice will be of continuing significance. As knowledge important to medicine continues to increase, the further development of specialism and its related tools and techniques will also take place. Although the availability of such specialty service is essential to good medical care, it is believed that it is similarly important that the broad, general outlook in medicine also be retained.

"The Committee is of the opinion that the needs of the public are well served through comprehensive medical care. By its very nature, such care is based necessarily upon a close interpersonal

relationship that most readily develops through long association between a physician and a patient. To have greatest significance, this close relationship also involves the physician with his patient's environment and, most particularly, with his family.

"In considering preparation for this type of medical practice in the future, the Committee devoted much thought to the titles that should be used for such a physician and such a medical practice. Because the emphasis is on the medical care of the family regardless of age and because of the wide acceptance and stature of the titles with the public, such a physician could most appropriately be designated a family physician and the field as family practice.

"For the working definition of the medical practice involved, the Committee adopted the following: 'Family practice is that aspect of medical care performed by the Doctor of Medicine who assumes comprehensive and continuing responsibility for the patient and his family regardless of age.'

"The educational program proposed for future family physicians is intended to prepare them to provide services to patients irrespective of age over broad areas of medicine and to coordinate specialty consultation and care according to the peculiar needs which their patient's problems may require. The Committee believes that there will be an increasing need for the family physician who is prepared to provide these services. . . .

"The Committee believes it to be in the best interests of medical practice, the public, and the profession itself that every physician should be free to follow that field of medicine which most appeals to him and for which he is most suited by ability and temperament. He should be trained adequately for that field which he elects to follow. The student contemplating his future career in family practice should have available to him recognized educational programs of high quality comparable to those existing in specialty areas. . . .

The Proposed Basic Program

"The proposed two-year program presented below should assure the opportunity for adequate preparation of the future physician to provide medical care for all members of the family. It should be emphasized that the proposed pro-

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gram is conceived in its entirety as concerned with the preparation of physicians in the future for family practice. It should not be interpreted by hospitals or other institutions or organizations as having import for the training or privileges of general practitioners now in practice.

"In recommending a new graduate program for the family practice of medicine, the Committee believes that primary consideration should be given to an educational experience enabling the physician to provide medical care for all members of the family irrespective of age. After determining that the period beginning at the time of receiving the M. D. degree is the most appropriate one for a new plan of preparation for family practice, the Committee agreed to concern itself with a minimal or basic program. Since the program is designed to fulfill a logical need, it is reasonable to anticipate that state board regulations, military obligations, and hospital staff policies and privileges will be altered to recognize the merits of this program.

Relationship to the Existing Internship

The internship year as presently constituted cannot be considered as a component of this program for it would result in dividing it into two separate segments. The internship was designed many years ago to provide the initial contact with and responsibility for patients. Since the development of the medical school clinical clerkship, the internship no longer comprises such initial patient contact but rather it is now considered as one of several graded steps toward the assumption of total responsibility for patient care. Further, there is now general agreement that the one-year internship alone is inadequate as preparation for the practice of medicine. Indeed, the Committee believes the one-year internship actually encourages inadequate preparation for family practice.

"The present values of the internship will be an inherent part of the proposed program, but cannot be separated out of it as a segment without weakening the greater values to be derived from dealing with the new program as a unified whole. The graduate program proposed as preparation for family practice is designed to be more comprehensive than the internship in regard to patient responsibility, educational content, and continuity of experience.

Minimal Requirements

"Under the existing circumstances, the Committee believes that a period of at least two years of formal hospital training following attainment of the medical degree is necessary in preparation for

the family practice of medicine. However, time alone cannot serve as a valid measure of educational adequacy. The two year period would be minimal even where the other factors of educational quality and content are optimal.

Medicine and Pediatrics

"Since in usual instances the participant will enter this program immediately following graduation from medical school, it should include a **minimum basic eighteen month period** to provide experience in the diagnostic, therapeutic, psychiatric, preventive, and rehabilitative aspects of medicine and pediatrics in a very broad sense, including care of the newborn. **In addition, there will be provided an elective period.**


"The graduate program of two years in preparation for family practice should be planned and implemented as a unified whole. Since the family physician is to provide continuing care, it is highly important that the preparation for this kind of practice be designed to assure suitable opportunity for the participant to study patients over relatively long periods of time. He should follow the patient, as necessary, in the outpatient service, into the home when this is practicable, and certainly from one hospital service to another (such as following his assigned patients from the medical or pediatric service through the surgical wards). There should be a maximum continuity of assignment in specific services so that the program will stress education through continuing rather than episodic medical experience. Such a unified two-year program will permit and encourage the necessary progression of responsibility.

Obstetrics and Gynecology

"The opportunity for training in obstetrics during the elective period should be a requisite of all programs. Participants who plan to practice obstetrics are expected to spend at least four months in obstetrical training. Physicians planning to undertake other than uncomplicated procedures should take additional advanced training in this field. For those who do not anticipate an obstetrical practice, the elective portion may be utilized for further training in other segments of the program. Experience should be provided in office-type gynecology (and the care of the newborn if not included in pediatrics). It is urged that the concept of unity be applied to the elective period to prevent unduly short assignments that would provide little educational justification.

Ambulatory and Outpatient Care

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of adequate opportunities for the study of outpatients is essential and should be provided throughout the program insofar as practical in a manner that would permit following the patient over long periods of time. . . .

Emergency Service and Surgery

"Throughout the two-year program, the participant should have experience provided by regularly assigned periods of emergency room service. The Committee believes that this should include training in minor surgery and the emergency and primary management of trauma. The emergency room service should also provide experience with the common medical and surgical emergencies and participation in their management. Participants in this program planning to undertake surgery other than minor surgery are expected to take additional advanced training.

Cooperation Essential

"This report presents the minimal program under optimal circumstances for preparation for family practice in the future. The Committee believes that this two-year program would furnish a sound foundation for further graduate medical education and for continuing education in any field. The thoughtful cooperation of specialty groups will be essential to its success.

"The Committee also recognizes that thoroughly sound implementation of the proposed program by medical staffs and governing boards of suitable hospitals will be required in order to realize fully its potentialities. The proposed program should receive the favorable attention of the best medical centers in this country. To achieve the ultimate objective of sound preparation in the future for family practice, this program should be initiated in suitable hospitals with the emphasis on quality. . . .

"The Council on Medical Education and Hospitals should be instructed to implement the intent of this report. Due attention should be given to the importance of initiating this new program on a modest scale so as to best assure that a high quality of educational experience will be a uniform characteristic of all such programs established. . . ."

Three Ohio physicians, Dr. J. Warkany, professor of pediatrics research, University of Cincinnati College of Medicine, and Dr. B. Pasamanick, professor of psychiatry, and Dr. H. Knobloch, associate professor of pediatrics, Ohio State University Health Center, participated on the program of the First International Medical Conference on Mental Retardation, Portland, Maine, July 27-31.

American College of Obstetricians and Gynecologists Announces Meetings

The American College of Obstetricians and Gynecologists has announced the scheduling of eight district meetings in the fall. The meeting for District V which includes Ohio will be in the Statler Hotel, Detroit, Mich., November 19-21. District chairman is Dr. Arthur G. King, 199 William Howard Taft Road, Cincinnati 19.

Additional information may be obtained from Dr. King or by writing Mr. Donald F. Richardson, Executive Secretary, American College of Obstetricians and Gynecologists, P. O. Box 749, Chicago 90, Illinois.

Get Ob-Gyn Certificates

The following Ohio physicians have been certified by the American Board of Obstetrics and Gynecology:

Canton: Edward E. Grable, James F. Kilduff; Cincinnati: William R. Puttmann; Cleveland: Paul O. Funk, Sol Gross, Joseph F. Morabito, Jerold M. Rosenblum, Lawrence A. Stevens; Cuyahoga Falls: George D. Solomon; Columbus: Lloyd W. Barnes, Jonathan G. Busby, Robert L. Hallet; Dayton: Howard E. McKnight; Youngstown: Irving Berke.

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In Memoriam . . .

Raymond W. Bradshaw, M.D., Massillon; Harvard Medical School, 1923; aged 66; died June 10; former member of the Ohio State Medical Association. Dr. Bradshaw for about 20 years prior to 1948 was in charge of the health services at Oberlin College. He left Ohio to accept an appointment on the staff of the Veterans Administration Hospital, Kerrville, Texas, and later took a post on the staff of the Abeline, Texas, State Hospital. For the past four years he was on the staff of the Massillon State Hospital. A veteran of World War I, he is survived by his widow, a daughter and a son, Dr. John S. Bradshaw, of Cleveland.

Malcolm Bronson, M.D., Hamilton; Miami Medical College, Cincinnati, 1908; aged 74; died May 31; member of the Ohio State Medical Association and the American Medical Association. A resident of Hamilton for most of his life, Dr. Bronson began his practice in Hood River, Oregon. Prior to World War I, he took residency work in eye, ear, nose and throat work in New York and abroad, and on his return to the United States established his practice in Hamilton. He retired in 1945. A member of the Episcopal Church, he is survived by his widow, a daughter, a son and a brother.

Josephine Danforth Gillett, M.D., North Madison; Cleveland Medical College, Homeopathic, 1897; aged 85; died June 28. Dr. Gillett practiced in Cleveland until 1920. For many years she was on the board of the Woman's Hospital and served as its secretary until 1939. Surviving are her husband, Ralph J. Gillett, a son and a daughter.

Robert B. Gilman, M.D., East Cleveland; aged 28; died June 26 in a traffic accident. Dr. Gilman had recently completed an internship in Boston, after attending Western Reserve University and Harvard Medical School. Survivors include his father and a sister.

Spencer Hagen, M.D., Cincinnati; Eclectic Medical College, Cincinnati, 1929; aged 55; died June 21; member of the Ohio State Medical Association, the American Medical Association and the International College of Surgeons; president-elect of the Cincinnati Surgical Society. A practicing physician in Cincinnati since 1930, Dr. Hagen was a former police and fire department surgeon and had only recently been named to the Hamilton County Commission. A veteran of World War II, he was a 32nd Degree Mason and a director of the

Ohio Eastern Star Home board. Surviving are his widow, three daughters, a son, his mother and a brother, Dr. J. Stewart Hagen, Jr., also of Cincinnati.

Bernard E. Ingmire, M.D., Plain City; Ohio State University College of Medicine, 1930; aged 56; died June 26; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice; president of the Union County Medical Society for several terms. Dr. Ingmire practiced medicine in Plain City for 28 years. Affiliations included membership in the Episcopal Church and several Masonic bodies. Surviving are a daughter and a son, his parents, three sisters and a brother, Dr. Joseph P. Ingmire, of Mt. Gilead.

Rey V. Luce, M.D., Santa Rosa, Calif.; Rush Medical College, 1913; aged 69; died May 30; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. Dr. Luce practiced in Akron from 1919 until 1946. In the latter year he retired and moved to California. His son, Rey V. Luce, Jr., recently received his medical degree from Stanford University. Two sisters also survive.

Paul H. Moore, M.D., Los Angeles, Calif.; Western Reserve University School of Medicine, 1918; aged 70; died June 8. A former resident of Toledo, Dr. Moore had been in Los Angeles for about 25 years.

Samuel Rothenberg, M.D., Cincinnati; Medical College of Ohio, Cincinnati, 1893; aged 87; died June 25; member of the Ohio State Medical Association and the American Medical Association; recipient of the OSMA 50-Year Award. Dr. Rothenberg began his practice in Cincinnati in 1895 after studying abroad for two years. He was director of the Department of Obstetrics at Jewish Hospital from 1921 until his retirement in 1942. Among many activities, he was a pioneer in the planned parenthood movement in the Cincinnati area and was a past-president of the United Jewish Social Agencies. Among survivors are his son, Dr. Robert C. Rothenberg, and his son-in-law and daughter, Dr. and Mrs. Richard A. Freiberg, all of Cincinnati; also a sister.

David Rubin, M.D., Cleveland; Western Reserve University School of Medicine, 1953; aged 33; died June 1; member of the Ohio State Medical Association. Dr. Rubin was a research fellow

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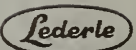
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at Western Reserve University, working on a project for the American Cancer Society. He is survived by his widow, three daughters, his mother, a brother and a sister.

Issac Frank Steiner, M. D., Sarasota, Florida; University of Michigan Medical School, 1897; aged 91; died June 19; former member of the Ohio State Medical Association. A native of Allen County, Dr. Steiner practiced medicine in Lima from 1893 to 1942. In the latter year he retired and moved to Florida. Survivors include his widow, a daughter and three sons. Dr. David L. Steiner, of Lima, is a nephew.

OSMA Committee Furnishes Health Material for PTA Units

All local units and councils of the Ohio Congress of Parents and Teachers will receive key health materials furnished by the Committee on School Health of the Ohio State Medical Association in packets which will be sent out in August from Ohio Congress headquarters. Literature requested by the State PTA organizations, and supplied by the Committee, include the booklet "What Everyone Should Know About Doctors"; a reprint of an article by Dr. Thomas E. Shaffer, of Columbus, entitled "Health Services School-Age Children Need" (*JAMA* reprint, April 5, 1959); a reprint of the article "The Best Defense Against Sex Perverts", which appeared in the November, 1958, issue of *Today's Health*; and a reprint of "Let 'Em Eat Hay", which appeared in the September, 1958, issue of *Today's Health*. Twenty-five hundred each of the above pieces of literature were furnished.

Committees on Aged Named

Governor DiSalle has named a seven-person committee to survey the needs of Ohio's aged persons with the aid of consultants. Members of the committee are: Mrs. James E. Fain, Dayton, chairman; Ernest Bohn, Cleveland; Mrs. Alexander Glockner, Columbus; Vernon L. Burt, Cleveland; Mrs. Frank M. Barry, Cleveland; Rabbi Sidney M. Berkowitz, Youngstown; and Mrs. Harvey Knowles, Jr., Cincinnati.

Ohioans named by Arthur S. Flemming, secretary of HEW, to an advisory committee for the White House Conference on Aging in January, 1961, are: Bohn, Rt. Rev. Raymond L. Gallagher, Cleveland; Mrs. Margaret A. Ireland, Cleveland; Rev. Karl P. Meister, Elyria; Louis B. Seltzer, Cleveland; and Mrs. Ella Phillips Stewart, Toledo.

Do You Know? . . .

At the recent 125th anniversary celebration of the Ohio State University College of Medicine, the Medical Alumni Association installed Dr. Thomas E. Rardin, Columbus, as president and elected Dr. Robert J. Murphy, Columbus, as president-elect, and Dr. Ernest W. Johnson, Columbus, as secretary, succeeding Dr. Murphy.

* * *

Architects are drafting plans for the new Ohio Rehabilitation Center building at the Ohio State University Health Center and bids will be let this Summer. The building will consist of a 34-bed unit with shops, treatment areas, classrooms and laboratories.

* * *

Ohio Chapter, American College of Surgeons, will hold its annual meeting September 11 and 12 at the Statler Hotel, Cleveland.

* * *

New president-elect of the American Trudeau Society is Dr. William B. Tucker, director of tuberculosis service for the VA in Washington, D.C. He will take office in 1960.

Lower Income Group Members Lost More Days from Work, Survey Shows

As a result of illness and injury, workers with family incomes under \$2,000 per year lost an average of 10.3 days from work during the 12 months ending June 30, 1958, as compared with a loss of 5.9 days for those in families earning \$7,000 and over, according to findings of the U. S. National Health Survey of the Public Health Service.

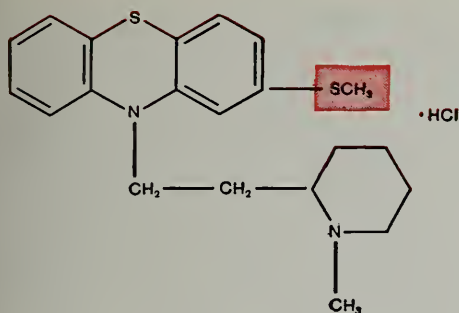
An inverse relationship existed also between income and other forms of restricted activity, such as days in bed due to illness and injury.

Workers 65 years of age and over lost about 11 days from work compared with 8.4 days for those in the 45-64 year group and 6.3 days for those aged 17-44.

City children lost 9 days from school, on the average, as a result of illness and injury; rural non-farm children lost 7.8 days; and farm children lost 7.3 days. However, farm children 15 and 16 years of age lost about 10 days from school as compared to 6.5 days lost by urban children of these ages.

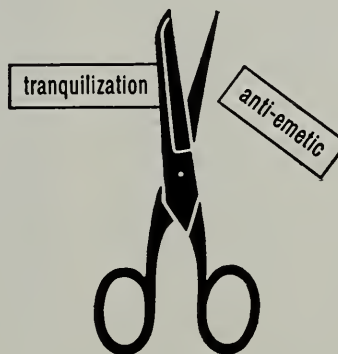
This information appears in the latest of a series of published statistical reports issued by the U. S. National Health Survey. The data apply to the total civilian population of the country, exclusive of persons confined to long-term institutions.

new advance in tranquilization? greater specificity of tranquilizing action results in fewer side effect

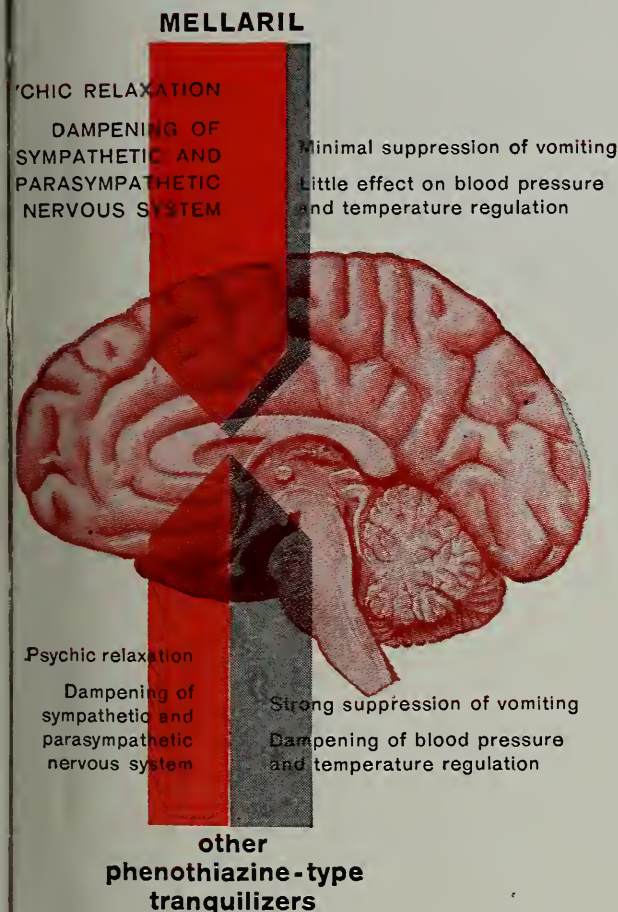


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- 3 A notable absence of extrapyramidal stimulation.
- 4 Lack of impairment of patient's normal drive and energy.
- 5 Virtual freedom from such toxic effects as jaundice, photosensitivity, skin eruptions, blood forming disorders.



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CHILDREN: BEHAVIOR PROBLEMS IN CHILDREN	10 mg. t.i.d.	20-40 mg.

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Stefeld, A. M.: Scientific Exhibit, American Academy General Practice, San Francisco, April 6-9, 1959



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Robert D. Zaas, Cleveland, University of Chicago; Russell S. Zanowick, Dayton, St. Louis Univ.; James B. Zimmerman, Dayton, Univ. of Maryland.

Changes Made in Rules and Forms Of VA Home Town Care Program

Effective July 1, 1959, Veterans Administration changed certain procedures relating to the Home Town Care Medical Program, which changes were explained in the following letter sent to all Ohio physicians currently treating eligible veterans by Dr. H. P. Timberlake, Chief Medical Officer, Regional VA office, Cleveland:

"Effective with the FY 1960 (7-1-59 to 6-30-60), the Veterans Administration has modified certain aspects of its fee-basis program. We hope a greater convenience to you will result.

"Authorizations for treatment will be issued in all cases, for a specific period—usually one fiscal year or from the date of issue to the end of the fiscal year. Renewal will be automatic if the patient's disability requires further treatment and the need is adequately justified in your reports. Services for conditions other than listed on the authority, cannot be approved.

"Authorized services are indicated by the total amount estimated to be appropriate for the period of the authorization. Actual distribution of the service is for your professional determination. Treatments rendered in excess of the amount estimated must, however, be explained and justified in the Report of Medical Treatment. Additional services not emergent, such as x-ray, laboratory, furnishing of appliances, etc., must be requested and approved in advance.

"The current program necessitates submitting the Report of Medical Treatment at the end of each month with the "Statement of Account for Medical Services." The latter form is new and being furnished for your use in lieu of personalized letterhead statements. Upon receipt of your monthly medical report and statement of account, a new set will be promptly mailed for completion at the end of the next month's treatment.

"Your Reports of Treatment will become a permanent and complete part of the veteran's medical history and they should therefore be as complete as possible and should include specific clinical information such as the patient's response to treatment, dosage, name of drug prescribed, results of laboratory tests (including negative findings), blood pressure reading, units of x-ray, etc. All reports should give the date(s) of service, findings, treatment, and diagnosis to permit us to properly evaluate the veteran's future treatment needs.

"The changes mentioned are set forth with the desire of attaining mutual satisfaction when providing outpatient treatment to eligible veterans. Please contact this office whenever you believe we may be of assistance."

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Ca Pantothenate	5 mg.
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Phosphorus (as CaHPO ₄)	122 mg.
Boron (as Na ₂ B ₄ O ₇ ·10H ₂ O)	0.1 mg.
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Activities of County Societies . . .

ADAMS

Dr. Alan Randall, assistant professor of anesthesiology at Ohio State University, Columbus, was guest speaker at the June 18 meeting of the Adams County Medical Society. His subject was "Recent Developments in Anesthesia." The meeting was held at the home of Dr. and Mrs. Alexander Salamon, Seaman, with members of the Woman's Auxiliary also present.

BELMONT

"The Practical Approach and Management of Allergy," was the subject discussed by Dr. Martin Reiter, Wheeling, W. Va., at the June 18 meeting of the Belmont County Medical Society. The dinner meeting was held in the Belmont Hills Country Club.

CLARK

The speaker for the May meeting of the Clark County Medical Society was Dr. S. J. Behrman, associate professor in the Department of Obstetrics and Gynecology at the University of Michigan. His topic was "Dysfunctional Uterine Bleeding."

CLERMONT

Members of the Clermont County Medical Society had as guests area newspapermen for the May meeting at the D-X Ranch. The discussion centered around public relations affecting physicians.

CLINTON

Dr. Charles Lovingood, vascular surgeon of Dayton, was the speaker at the luncheon meeting of the Clinton County Medical Society Tuesday (June 2) at the General Denver Hotel. Dr. Maxine Hamilton, vice-president, presided in the absence of Dr. Robert M. Cronebaugh.—*Wilmington News Journal*.

COLUMBIANA

Two Ohio State University professors were guest speakers at the Columbiana County Medical Society (May) meeting at the Wick Hotel in Lisbon. Forty county doctors were in attendance.

Dr. Arthur James, professor of surgery and president of the Ohio State Cancer Society, and Dr. Geo. Hamwi, professor of medicine, discussed "Surgical and Medical Treatment of Thyroid Diseases."

The health poster contest planned for the county fair was also discussed.

Dr. Thomas Boles of Children's Hospital in Columbus was guest speaker at a meeting of the Columbiana County Medical Society Tuesday night (June 16) at the Wick Hotel in Lisbon.

The speaker discussed surgical treatment of newborn with congenital malformations.

Dr. William Kolozsi presided at the business meeting. Comprehensive booklets on mental health resources of the area were distributed to the 26 doctors present.

The booklet, authorized by the Columbiana County Health Association and approved by the Medical Society, was compiled by Marilyn Solak of the department of education of Columbiana County.

The next meeting of the society will be in September.—*Salem News*.

MERCER

Approximately 40 persons attended a joint meeting in May of the Mercer County Medical Society and the Mercer County Bar Association at the Bay View Lodge. The guest speaker was Don Juan Fernandez, a Chicago stock broker, public relations man and public speaker who chose as his topic "Investment Opportunities in the Atomic and Space Age."

This year's program found the doctors entertained by the attorneys. Don Meyers served as toastmaster and chairman of the Entertainment Committee, assisted in the latter chore by Dean James.

Attorney Don Montgomery, President of the Mercer County Bar Association, delivered the welcoming remarks of his fellow attorneys and Dr. Julius Schweiger, President of the Mercer County Medical Association, responded on behalf of the doctors.—*Celina Standard*.

MONTGOMERY

Dr. Charles G. Lovingood was elected "president-elect for 1960" of the Montgomery County Medical Society last night. He will serve as president in 1961.

Other officers elected at the annual meeting held at Wright-Patterson Air Force base were Dr. Charles E. O'Brien, vice-president; Dr. William J. Lewis, secretary, and Dr. Kenneth D. Arn, treasurer; Dr. Paul Troup, trustee; Dr. Robert A. Bruce, delegate, and Dr. J. Richard Strawsburg, alternate delegate.

Installed as president for the remainder of the year was Dr. Harry A. Bremen, formerly vice-president, who succeeds Dr. A. J. Carlson, president, who is leaving Dayton.

The 1960 president will be Dr. E. Wallace Smith. Guest speaker was Col. George M. Knauf, staff surgeon at the Air Force Missile Training center at Patrick Air Force base, Cape Canaveral, Florida. He spoke on "Medical Aspects of Missile Operations."—*Dayton News*.



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Activities of Woman's Auxiliary . . .

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(See Page 1042 for roster of officers.)

CUYAHOGA

At the OSMA Convention in Columbus in April the Woman's Auxiliary to the Academy of Medicine of Cleveland was the recipient of the State Certificate for "planning and executing the best all-inclusive auxiliary program" in groups of 300 members or more. It also won the State AMEF award for the largest contribution in Ohio. Members installed at the Convention include Mrs. Christopher Colombi, State Auxiliary president, Mrs. Vincent Kaval, corresponding secretary, and Mrs. John B. Hazzard, Fifth District director.

At the National AMA Convention in Atlantic City in June eight auxiliary members were present when Mrs. Frederic Rittinger accepted the National AMEF Award of Merit. The Cuyahoga County Auxiliary had raised the greatest sum of money of any auxiliary to date, \$4,605.00 for AMEF. This amount was raised primarily by the Christmas card project. The project is being repeated this year with a newly designed card which has been offered to the other 60 Auxiliaries in the State.

The Woman's Auxiliary of Cuyahoga County met May 22 at the College Club for its Annual Meeting. Mrs. Frederic Rittinger, retiring president, introduced Mrs. C. H. Bell, immediate past-president of the State Auxiliary who installed the following officers: Mrs. Frank Meany, president, Mrs. Garry Bassett, president-elect; Mrs. J. Kenneth Potter, vice-president; Mrs. Milton E. Bobey, recording secretary; Mrs. Myron M. Perlich, corresponding secretary; Mrs. Thomas L. Manning, treasurer; and Mrs. Fred B. Kelly, assistant treasurer. One of the members, Mrs. Richard Schenck, of the Cleveland Playhouse Staff, gave a monologue titled: "The Doctor's Wife."

For the third consecutive year the Auxiliary was invited to entertain at the Annual Meeting of the Cleveland Academy of Medicine. On May 15 the ladies presented a skit titled: "Diet is a Girl's Best Friend" authored by members, Mrs. Myron Perlich and Mrs. Richard Schenck, (with an assist from the San Diego Auxiliary.)

HAMILTON

On May 19 the Woman's Auxiliary to the Academy of Medicine of Cincinnati held its annual picnic at the Maketewah Country Club. The program chairman for the day, Mrs. Walter G. Engel and her vice-chairman, Mrs. Merton F. Wilson conducted a talent auction for the day's enter-

tainment, with Mrs. Robert Woolford acting as the auctioneer. Proceeds from the event will be used for the restoration of the auxiliaries yearly books. Mrs. James S. Mills and Mrs. Leo S. Smyth were hospitality chairmen for the day.

Installation of new officers for 1959-60 took place. Mrs. Don Berning, the new president, received the official gavel from Mrs. Earl Van Horn, the retiring president. Serving with Mrs. Berning will be Mrs. William Ahlering, president-elect; Mrs. William Roach, vice-president; Mrs. Alfred Erb, recording secretary; Mrs. Bert McBride, corresponding secretary; Mrs. Charles Hoyt, treasurer, and Mrs. Daniel Jones, Mrs. Carl Schilling, Mrs. Richard Vilter, Mrs. Roy Kile, Mrs. William Lippert and Mrs. Robert Pierce as directors.

On May 26 a joint board meeting of the newly elected and retiring officers and board members of the Woman's Auxiliary to the Academy of Medicine of Cincinnati was held at the Maketewah Country Club. Recommendations were made to the new board for their plans for the year.

LUCAS

An outstanding member of the Woman's Auxiliary of Lucas County is Mrs. Adelbert J. Kuehn. She is a member of the Board and serves as chairman of "Citizens' Day Care for Children," a program which Mrs. Kuehn organized and the auxiliary co-sponsors.

Mrs. Kuehn realized that many elementary school children had inadequate food and care during their lunch hour and she decided to do something about it. Enlisting the help and support of the Auxiliary to the Academy of Medicine, Zonta International, Toledo Council of Churches, Council of Social Agencies and AAUW, she organized the Citizens' Day Care for Toledo School Children for the 6 to 12 year-old age group. The only group of its kind in the country that carries on its work entirely by volunteers, it provides hot lunches and noon supervision in two churches, five days a week, throughout the school year.

These children come from homes where working parents, sick mothers, or broken homes make help necessary.

MAHONING

A Board meeting was held May 27 at the home of Mrs. A. E. Rappaport, president.

The program for the coming year was proposed with its purposes to (1) interest members in the aims of the Auxiliary and the American

Medical Association, (2) cooperate with the Mahoning County Medical Society, (3) include programs which explain community issues which are of interest to all citizens, and (4) encourage a warmth of fellowship among physicians' families.

The opening metting will be September 22 at the home of Mrs. John Noll. At that time old and new members will be greeted and a panel discussion on Para-Medical Education will be held.

Mrs. W. H. Evans, a past-president, has recently been re-elected, to a one year term, as a Director of the American Medical Association's Woman's Auxiliary at the national convention in Atlantic City.

**Second Councilor District
To Meet October 21**

The Clark County Medical Society will be host to the Second Councilor District Meeting October 21 at the Springfield Country Club.

The scientific program will begin at 1:30 P. M., with Dr. Geo. J. Hamwi, professor of medicine and chief, Division of Endocrinology and Metabolism, Ohio State University College of Medicine, speaking on "Oral Hypoglycemics and Various Enzyme Preparations."

Dr. Harvey Knowles, University of Cincinnati College of Medicine, will speak on "Diabetes in the Adolescent," followed by Dr. Elsie Carrington, Temple University School of Medicine, speaking on "Diabetes in Pregnancy." The last speaker will be Dr. E. Stanley Crawford, Baylor University School of Medicine, speaking on "Vascular Surgery in Diabetes."

A social hour will follow the afternoon program, with dinner at 6 P. M. At 7 P. M. the speakers will serve as a panel to answer questions submitted during and after the afternoon program. Dr. Hamwi will serve as moderator.

Dr. Paul Schanher, Springfield, is chairman of the program committee, and Dr. Frank W. Anzinger, Springfield, is chairman of the arrangements committee. Reservations for the dinner may be sent to Dr. Anzinger at 444 West Harding Road, Springfield. Dinner tickets are \$6 each.

AAMA Opens National Office

The American Association of Medical Assistants has opened a national office at 510 North Dearborn Street, Chicago 10. Mrs. Stella Thurnau of Elgin, Ill., has been named the organization's executive secretary. She formerly worked at AMA headquarters in Chicago. The group has chapters in 21 states and members-at-large in seven others.

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General Practitioners in Particular Will Be Interested in This Course
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GENERAL PRACTITIONERS will receive special credit from the Ohio Academy of General Practice for a course in pulmonary diseases sponsored by the Ohio State University College of Medicine and four other sponsoring organizations. The course is scheduled on the OSU Campus, Columbus, Friday and Saturday, September 25 and 26.

Sponsors are the Ohio State University College of Medicine, the Ohio State Medical Association, Ohio Trudeau Society, American Trudeau Society, and the Ohio Tuberculosis and Health Association.

Reservations for the course, accompanied by a check for \$25.00 should be sent to: Harold L. Autrey, Treasurer, Ohio Tuberculosis Hospital, Columbus 10, Ohio. Registration is limited to 150 and applications must be received by September 8, 1959.

Hotel reservations should be made with the hotel of choice. The Fort Hayes Hotel has reserved a limited number of rooms until September 8, 1959. (The football weekend makes this early reservation necessary.)

An additional attraction is the Ohio State-Duke University football game on Saturday afternoon, September 26.

The registration fee includes one ticket for the banquet on Friday evening. Extra tickets at \$5 each may be secured for those who wish to bring their wives.

The course has been designed to provide the physician in general practice with current concepts of pulmonary disease, cardiac surgery, and carcinoma with emphasis on practical aspects of diagnosis and treatment.

The banquet speaker will be Richard A. Prindle, M. D., Chief of the Air Pollution Medical Program of the United States Public Health Service. He will discuss air pollution.

Other speakers will include James Monroe, M. D., Assistant Director of Ray Brook State Tuberculosis Hospital, Ray Brook, New York, who will discuss "Present Status of Chemotherapy"; Katharine R. Boucot, M. D., Professor of Preventive Medicine, Women's Medical College, Philadelphia, "Detection of Curable Lung Cancer"; George W. Wright, M. D., Head of the Medical Research Department of St. Luke's Hospital, Cleveland, "Pulmonary Emphysema"; and H. S. Van Ordstrand, Chief of the Department of Pulmonary Diseases, Cleveland Clinic, "Differential Diagnosis of Pleural Fluids."

Additional speakers will include members of the staff of the Ohio State University College of Medicine and others.

The program will be held in the Ohio Union Conference Theater, Ohio State University, High Street at 13th Avenue. The banquet will be held in the Gold Room, Fort Hayes Hotel, Columbus.

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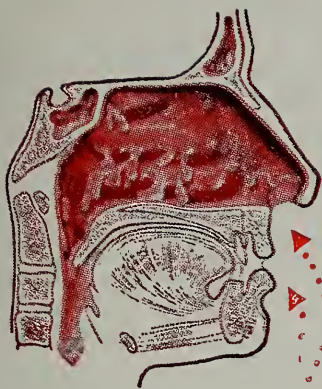
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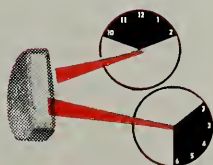
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COMING MEETINGS

Academy of Psychosomatic Medicine, Sheraton-Cleveland Hotel, Cleveland, October 15-17.

American Medical Association, Clinical Session, Dallas, Texas, November 3-6.

American Association of Medical Assistants, Benjamin Franklin Hotel, Philadelphia, Pa., October 16-18.

American College of Surgeons, Traymore Hotel, Atlantic City, September 28-October 2.

American College of Surgeons, Ohio Chapter, Statler Hotel, Cleveland, September 11-12; Dr. Berton M. Bogle, 311 S. Market St., Troy, Ohio, Secretary-Treasurer.

American Heart Association, Annual Meeting and Scientific Sessions, Philadelphia, October 23-27.

American Hospital Association, 61st Annual Meeting, New York City Coliseum, August 24-27.

American Medical Writers' Association, Chase Hotel, St. Louis, October 2-3. Dr. Harold Swanberg, 510 Maine St., Quincy, Ill., Secretary.

American Roentgen Ray Society, Netherland Hilton Hotel, Cincinnati, September 22-25; Dr. C. Allen Good, Mayo Clinic, Rochester, Minn., Secretary.

Kentucky State Medical Association, Louisville, Ky., September 22-24.

Medical Society of the State of Pennsylvania, Penn-Sheraton Hotel, Pittsburgh, October 18-23.

Northwestern Ohio Medical Association, Findlay Country Club, October 7, all-day session; registration 9:00 a.m.; first speaker, 9:45 a.m.

Ohio Chapter, American College of Surgeons, Annual Meeting, Statler Hotel, Cleveland, September 11, 12.

Second District Postgraduate Program, Springfield, October 21.

AAPS Essay Contest Will Be Sponsored Again in 1960

The Association of American Physicians and Surgeons has announced that it will sponsor its 14th annual Essay Contest for high school students in 1960. High school students will have a choice of topics: "The Advantages of Private Medical Care" or "The Advantages of the American Free Enterprise System."

AAPS will award \$2,675 in national prizes, which includes a \$1,000 first prize. Inquiries regarding the contest should be addressed to Dr. Robert J. Moorhead, Chairman, AAPS Essay Contest Committee, Suite 318, 185 North Wabash Avenue, Chicago 1, Illinois.

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(Continued on Next Page)

STATE ASSOCIATION OFFICERS AND COMMITTEEMEN (Continued)

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COUNTY SOCIETIES' OFFICERS AND MEETING DATES

FIRST DISTRICT

ADAMS—Samuel B. Sonkin, President, Main St., West Union; Alexander Salamon, Secretary, Seaman. 3rd Wednesday, April, June, August, October and December.

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BUTLER—Clyde G. Chamberlin, President, 300 Rentschler Bldg., Hamilton; Mr. Charles G. Greig, Executive Secretary, 110 N. Third St., Hamilton. 4th Wednesday of alternate months.

CLERMONT—Cecil F. Barber, President, Felicity; Harry M. Breuer, Secretary, 224 George St., New Richmond. 3rd Wednesday, monthly.

CLINTON—Robert M. Cronebaugh, President, 116 N. Broadway, Blanchester; John K. Williams, Secretary, 100 W. Main St., Wilmington. 2nd Tuesday, monthly.

HAMILTON—J. Robert Hudson, President, 152 E. Fourth St., Cincinnati 2; Mr. Edward F. Willenborg, Executive Secretary, 152 E. Fourth St., Cincinnati 2. 3rd Tuesday, monthly, September through May.

HIGHLAND—J. Martin Byers, President, 316 Midway, Greenfield; Kenneth Lyle Upp, Secretary, 136 S. Washington St., Greenfield. 1st Wednesday, monthly.

WARREN—Thomas E. Fox, President, 309 Reading Rd., Mason; D. Paul Ward, Secretary, Box 85, Pleasant Plain. 2nd Tuesday, monthly.

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CLARK—William P. Montanus, President, 301 Home Rd., Springfield; Martin J. Cook, Secretary, 1054 E. High St., Springfield. 3rd Monday, monthly.

DARKE—Jesse L. Heise, President, Pittsburg; Emmett W. Arnold, Secretary, Court House, Greenville. 3rd Tuesday.

GREENE—Paul C. Vernier, President, 67 Xenia Drive, Fairborn; Quinten L. Erd, Secretary, S. Limestone, Jamestown. 2nd Thursday, monthly.

MIAMI—William W. Weis, President, 404 W. Wayne St., Piqua; Dale A. Hudson, Secretary, 221 Orr-Flesh Bldg., Piqua. 1st Friday, Monthly.

MONTGOMERY—Harry A. Bremen, President, 560 Fidelity Medical Building, Dayton 2; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Medical Bldg., Dayton 2. First Friday, monthly.

PREBLE—E. P. Tritschuh, President, 309 E. Main St., Lewisburg; Birna R. Smith, Secretary, 203 Commerce St., Lewisburg.

SHELBY—Clayton B. Conover, President, 316 S. Main Ave., Sidney; Ned A. Smith, Secretary, 739 Spruce St., Sidney. 1st Tuesday, monthly.

THIRD DISTRICT

ALLEN—Roger L. Tecklenberg, President, 700 Cook Tower, Lima; Thomas D. Allison, Secretary, 401 Steiner Bldg., Lima. 3rd Tuesday, monthly, except June, July, August.

AUGLAIZE—Robert J. Herman, President, 611 W. Mechanic St., Wapakoneta; Robert S. Oyer, Secretary, 310 Perry St., Wapakoneta. Called meetings.

CRAWFORD—Donald R. Wenner, President, 117 S. Poplar St., Bucyrus; Arnold Eicens, Secretary, 406 S. Sandusky St., Bucyrus. 3rd Thursday, monthly.

HANCOCK—M. Wesley Feigert, President, Ohio Bank Bldg., Findlay; Benjamin H. Saunders, Jr., Secretary, 1900 S. Main St., Findlay. 3rd Tuesday, monthly.

HARDIN—Wm. F. Binkley, President, 210 W. Columbus St., Kenton; Jack C. Lindsey, Secretary, 214 N. Main St., Kenton. 2nd Tuesday, monthly.

LOGAN—Charles A. Browning, Jr., President, 445 E. Columbus Ave., Bellefontaine; Paul E. Hooley, Secretary, N. Main St., DeGraff. 1st Friday, monthly.

MARION—Thomas N. Quilter, President, 1040 Delaware Ave., Marion; Robert L. Stuber, Secretary, 399 E. Church St., Marion. 1st Tuesday, monthly.

MERCER—Julius Schwiager, President, Fort Recovery; Terrence J. Kerrigan, Secretary, 204 W. North St., Coldwater. 3rd Thursday, monthly.

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SENECA—Thomas W. Watkins, President, 34 W. Market St., Tiffin; Robert R. Schwalenberg, Secretary, 34 W. Market St., Tiffin. 3rd Tuesday, every other month.

VAN WERT—Jack H. Cox, President, 301 N. Washington St., Van Wert; Ralph E. Rasor, Jr., Secretary, 507 S. Washington St., Van Wert.

WYANDOT—Clarence B. Schoolfield, President, 206 S. Main St., Upper Sandusky; Franklin M. Smith, Secretary, E. Saffle Ave., Box 68, Sycamore. 2nd Tuesday, monthly, except July and August.

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DEFIANCE—Thad J. Earl, President, 1132 E. Second St., Defiance; Francis M. Lenhart, Secretary, 207 Summit St., Defiance.

FULTON—Edwin R. Murbach, President, 224 N. Defiance St., Archbold; Robert A. Ebersole, Secretary, 203 DeGross Ave., Archbold. 2nd Tuesday, monthly.

HENRY—Edwin C. Winzeler, President, 812½ N. Perry St., Napoleon; Thomas F. Tabler, Secretary, 332 Railway Ave., Holgate. 1st Tuesday, monthly.

LUCAS—Maurice A. Schnitker, President, 1006 Secor Hotel, Toledo 3; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Blvd., Toledo 10. 3rd Tuesday, monthly.

OTTAWA—Cyrus R. Wood, President, 115 Madison St., Port Clinton; Robert W. Minick, Secretary, 124½ W. Water St., Oak Harbor. 2nd Thursday, monthly.

PAULDING—Edythe C. Pritchard, President, 509 N. Williams St., Paulding; D. E. Farling, Secretary, Main St., Payne. 3rd Wednesday, monthly.

PUTNAM—Walter E. Martin, President, 135 N. High St., Columbus Grove; Will W. Moody, Secretary, Vaughnsville. 1st Tuesday, monthly.

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WILLIAMS—Robert W. Dilworth, President, Main St., Montpelier; E. K. Bell, Secretary, P. O. Box 466, Bryan. Monthly meeting date varies.

WOOD—Stewart J. Smith, President, 106 N. Main St., Bowling Green; Richard L. Pearce, Secretary, 320 S. Main St., Bowling Green. 3rd Thursday, monthly.

FIFTH DISTRICT

ASHTABULA—Lewis H. Roth, President, 80 S. Broadway, Geneva; Albin F. Urankar, Secretary, Ashtabula Gen. Hospital, Ashtabula.

CUYAHOGA—Eugene A. Ferreri, President, 4070 Mayfield Road, Cleveland 21; Mr. Robert A. Lang, Executive Secretary, 2009 Adelbert Rd., Cleveland. 2nd Tuesday, monthly.

GEAUGA—George Dandalides, President, Chardon Medical Center, Chardon; Alton W. Behm, Secretary, 112 South St., Chardon. 2nd Friday, monthly.

LAKE—Richard W. McBurney, President, 124 S. St. Clair St., Painesville; Mrs. Owen A. McLaren, Executive Secretary, 1051 Cadle Ave., Mentor.

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COLUMBIANA—William A. Kolozsi, President, 616 E. Seventh St., Salem; Leonard S. Pritchard, Secretary, 153 S. Main St., Columbiana. 2nd Tuesday, monthly.

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PORTAGE—Charles C. Whitsett, President, Robinson Memorial Hospital, Ravenna; Don P. VanDyke, Secretary, 607 E. Main St., Kent. 3rd Tuesday, monthly.

STARK—John R. Seesholtz, President, 1645 Cleveland Ave., N. W., Canton; Mr. E. M. Sprunger, Executive Secretary, 405 Fourth Street, Canton 2. 2nd Thursday, monthly, except May, June, July, August and September.

SUMMIT—Donald I. Minnig, President, 640 W. Market St., Akron; Mr. S. H. Mountcastle, Executive Secretary, 437 Second National Building, Akron. 1st Tuesday, monthly, September through June.

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HARRISON—Elias Freeman, President, 264 S. Main St., Cadiz; Janis Trupovnieks, Secretary, High St., Box 366, Hopedale.

JEFFERSON—Ernest L. Perri, President, 517 N. Fourth St., Steubenville; Jacob Mervis, Secretary, Sinclair Bldg., Steubenville. 2nd Tuesday, monthly.

MONROE—Byron Gillespie, Secretary, South Main Street, Woodsfield.

TUSCARAWAS—Chester A. Bennett, President, 533 Wooster Ave., Dover; George D. Woodward, Secretary, 201 Boulevard, Dover. 2nd Thursday, monthly.

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FAIRFIELD—Lloyd L. Kersell, President, 130 Union St., Lancaster; Arthur B. VanGundy, Secretary, 843 N. Columbus St., Lancaster. 2nd Tuesday, monthly.

GUERNSEY—Jesse B. Kellum, President, 840 Wheeling Ave., Cambridge; Thomas D. Swan, Secretary, 651 Wheeling Ave., Cambridge. 1st Thursday, monthly.

LICKING—Kurt J. Fleisch, President, 125 Hudson Ave., Newark; Jay Ross Wells, Secretary, 375 Granville St., Newark. Last Tuesday, monthly.

MORGAN—A. H. Whitacre, President, Chesterhill. Called meetings.

MUSKINGUM—J. Herbert Bain, President, 67 W. Main St., New Concord; William A. Knapp, Secretary, 1025 Maple Ave., Zanesville. 1st Tuesday, monthly.

NOBLE—Charles F. Thompson, President, Caldwell; E. G. Ditch, Secretary, Caldwell. 1st Tuesday, monthly.

PERRY—Charles E. Bope, President, Somerset; O. D. Ball, Secretary, 203 N. Main St., New Lexington. Called meetings.

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NINTH DISTRICT

GALLIA—Thomas W. Morgan, President, Holzer Hospital, Gallipolis; Norman W. Pinschmidt, Secretary, Gallipolis Clinic, 52 State Street, Gallipolis. 3rd Thursday, monthly.

HOCKING—George B. Watson, President, Box 296, Adelphi; Howard M. Boocks, Secretary, Court House, Logan. Indefinite meeting dates.

JACKSON—Tom Washam, President, 35 Vaughn St., Jackson; Brinton J. Allison, Secretary, 267 Ralph St., Jackson. Called meetings.

LAWRENCE—Gerard C. Geswein, President, 1626 S. Sixth St., Ironton; George Newton Spears, Secretary, 422 South Sixth Street, Ironton. Monthly meetings on call.

MEIGS—Charles J. Mullen, President, 210½ E. Main St., Pomeroy; Selim J. Blazewicz, Secretary, 112½ E. Main St., Pomeroy. Last Wednesday, monthly.

PIKE—Paul H. Jones, President, Stockdale; George W. Cooper, Secretary, Piketon. 1st Tuesday, monthly.

SCIOTO—Ralph W. Lewis, President, 1025 Ninth St., Portsmouth; Carl H. Laestar, Secretary, 2829 Gallia St., Portsmouth. 2nd Monday, monthly.

VINTON—Richard E. Bullock, President, McArthur.

TENTH DISTRICT

DELAWARE—Max W. Livingston, President, 28 North Vernon, Sunbury; Edward C. Jenkins, Secretary, c/o Mrs. Mabel Barrett, Jane M. Case Hospital, Delaware. 3rd Tuesday, monthly.

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COUNTY SOCIETIES' OFFICERS AND MEETING DATES (Continued)

FAYETTE—H. Wm. Payton, President, 36 S. Main St., Jeffersonville; Marvin H. Roszmann, Secretary, 107 N. North St., Washington C. H. 2nd Tuesday, monthly.

FRANKLIN—James L. Henry, President, 244 E. Park St., Grove City; Mr. William Webb, Executive Secretary, 79 East State Street, Columbus 15. Meetings in January, February, March, May, September, November and December.

KNOX—Henry T. Lapp, President, 4 Public Square, Mt. Vernon; Thomas L. Bogardus, Secretary, 50 Public Square, Mt. Vernon. Quarterly meetings.

MADISON—William T. Bacon, President, 40 E. First St., London; Paul G. H. Wolber, Secretary, 40 E. First St., London. 2nd Wednesday, monthly.

MORROW—Andrew Maciurak, President, 119 E. Main St., Cardington; William S. Deffinger, Secretary, Marengo. First Tuesday, monthly.

PICKAWAY—Henry H. Swope, President, 233 N. Court St., Circleville; Edward L. Montgomery, Secretary, 108 Seyfert Ave., Circleville. 1st Friday, monthly.

ROSS—Robert E. Quinn, President, 30 N. Walnut St., Chillicothe; G. Howard Wood, Secretary, 134 W. Main St., Chillicothe. 1st Thursday, monthly.

UNION—Paul R. Zaugg, President, 130 N. Maple St., Marysville; May B. Zaugg, Secretary, 130 N. Maple St., Marysville. 2nd Tuesday, monthly.

ELEVENTH DISTRICT

ASHLAND—R. Lee Schafer, President, 203 Maple Street, Ashland; Wayne C. Smith, Secretary, 140 Claremont Ave., Ashland. 1st Friday, monthly, except July, August.

ERIE—Richard F. Hoffman, President, Providence Hospital, Sandusky; Edward P. Gillette, Jr., Secretary, 410 Columbus Ave., Sandusky. Monthly meeting date varies.

HOLMES—Clyde Bahler, President, Walnut Creek; Luther W. High, Secretary, R. F. D. 4, Millersburg. 2nd Wednesday, monthly.

HURON—Walter A. Drury, President, Box 269, Willard; John V. Emery, Secretary, Box 269, Willard. 2nd Wednesday, March, June, September and December.

LORAIN—Denis A. Radefeld, President, 209 Sixth St., Lorain; Mrs. C. Ruth Zealley, Executive Secretary, 311 Elyria Block, Elyria. 2nd Tuesday, monthly.

MEDINA—Robert E. Smith, President, 403 East Liberty St., Medina; William G. Halley, Secretary, 115 Bank Street, Lodi. 3rd Thursday, monthly.

RICHLAND—Riley E. Frush, President, 36 S. Mulberry St., Mansfield; James O. Ludwig, Secretary, 336 Sturges Ave., Mansfield. 3rd Thursday, monthly.

WAYNE—Ralph I. Cottle, President, 230 N. Market St., Wooster; Robert E. Schulz, Secretary, Wooster Community Hospital, Wooster. 2nd Wednesday, monthly.

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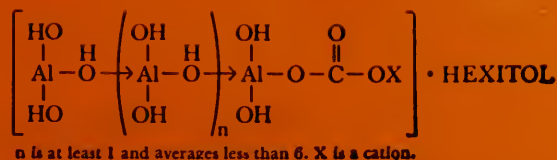
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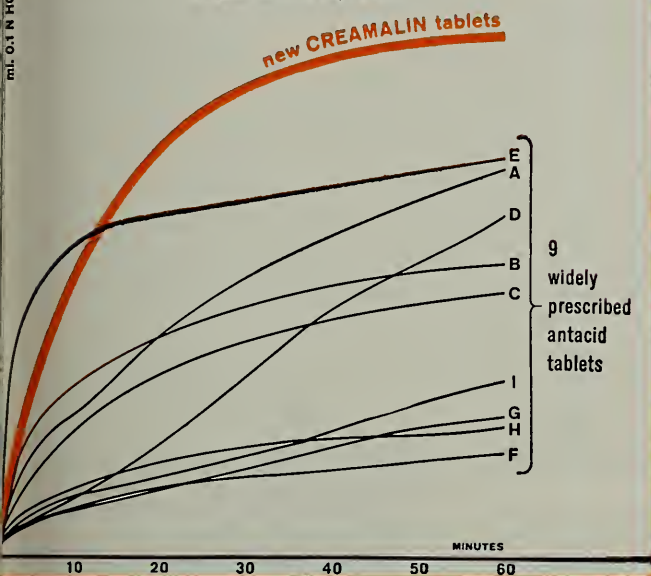
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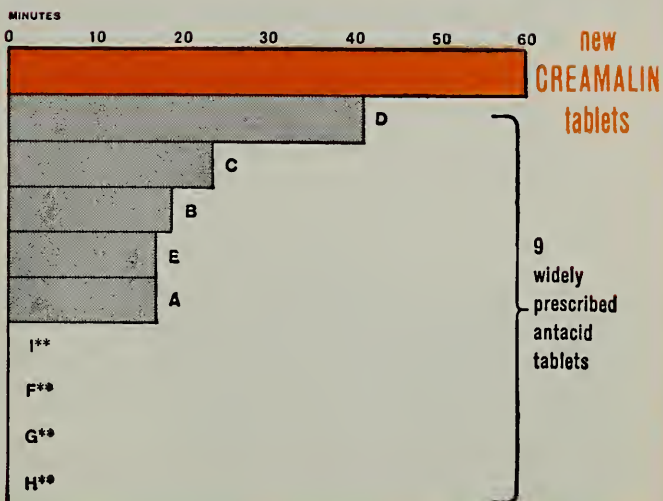
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CREAMALIN NEUTRALIZES MORE ACID LONGER More Lasting Relief

Duration of action at pH from 3 to 5*
(per gram of active ingredients)



*Hinkel, E. T., Jr., Fisher, and Tainter, M. L.: A new highly reactive aluminum hydroxide complex for gastric hyperacidity. To be published.

**pH stayed below 3.

Do antacids have to taste
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No chalky taste. New CREAMALIN tablets are not chalky, gritty, rough or dry. They are highly palatable, soft, smooth, easy to chew, mint flavored.

- NO ACID REBOUND • NO CONSTIPATION
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Adult Dosage: Gastric hyperacidity: 2 to 4 tablets as necessary. Peptic ulcer or gastritis: 2 to 4 tablets every two to four hours. Tablets may be chewed, swallowed with water or milk, or allowed to dissolve in the mouth.

Supplied: Bottles of 50, 100, 200 and 1000.

Winthrop

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The Physician's Bookshelf

(Books received from publishers. *The Journal* is not obligated to list herein every book received. It will try to list those which appear to be of greatest interest.)

* * *

Evolution of Nervous Control from Primitive Organisms to Man, by Allan D. Bass. (\$5.75, Publication No. 52, *The American Association for the Advancement of Science*, Washington 5, D.C.)

Psychotherapy and Society, by W. G. Eliasberg, M. D. (\$6.00, *Philosophical Library, Inc.*, New York 16, New York.)

Carcinogenesis; Mechanisms of Action, by G. E. W. Wolstenholme and Maeve O'Connor, editors for the Ciba Foundation. (\$9.50, *Little, Brown and Company*, Boston 6, Massachusetts.)

Regulation of Cell Metabolism, by G. E. W. Wolstenholme and Cecilia M. O'Connor, editors for the Ciba Foundation. (\$9.50, *Little, Brown and Company*, Boston 6, Massachusetts.)

A Way of Life and Other Selected Writings of Sir William Osler, by a Committee of the Osler Club of London with the help of W. W. Francis and others. (\$1.50, *Dover Publications, Inc.*, New York 14, New York.)

Respiratory Physiology and Its Clinical Application, by John H. Knowles, M. D. (\$5.25, *Harvard University Press*, Cambridge 38, Mass.)

Cancer in Families, by Douglas P. Murphy, M. D., and Helen Abbey, Sc. D. (\$2.50, published for The Commonwealth Fund by *Harvard University Press*, Cambridge 38, Mass.)

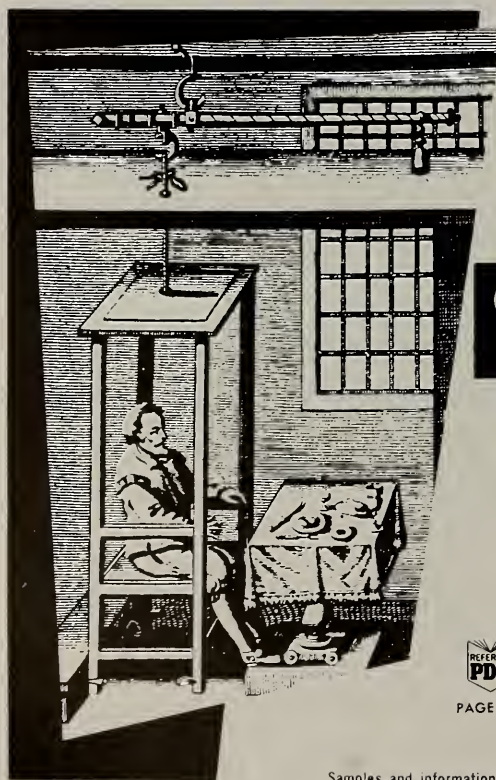
Steroids, by Louis F. Fieser and Mary Fieser. (\$18.00, *Reinhold Publishing Corporation*, New York 22, New York.)

Metals and Engineering In Bone and Joint Surgery, by Charles O. Bechtol, M. D., Albert B. Ferguson, Jr., M. D., Patrick G. Laing, M. B. (\$8.00, *The Williams & Wilkins Company*, Baltimore 2, Maryland, exclusive U. S. agents.)

Complex / Archetype / Symbol in the Psychology of C. G. Jung, by Jolande Jacobi. (\$3.00, Bollingen Series LVII, published by *Pantheon Books Inc.*, New York 14, N. Y.)

Surgery of the Foot, by Henri L. DuVries, M. D. (\$12.50, *The C. V. Mosby Company*, St. Louis 3, Missouri.)

Synopsis of Ear, Nose, and Throat Diseases, by Robert E. Ryan, M. D., William C. Thornell, M. D., and Hans von Leden, M. D. (\$6.75, *The C. V. Mosby Company*, St. Louis 3, Missouri.)



Sanctorius on his steelyard chair in the act of weighing himself for a metabolism experiment

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Amobarbital	45 mg.	Ferrous Sulfate	20.0 mg.
Vitamin A	6,600 Units	Cobalt Sulfate	0.49 mg.
Vitamin D	400 Units	Copper Sulfate	2.8 mg.
Vitamin B-1	1.6 mg.	Sodium Molybdate	0.45 mg.
Vitamin B-2	2.5 mg.	Zinc Sulfate	3.9 mg.
Niacinamide	15.5 mg.	Potassium Iodide	0.13 mg.



PAGE 826

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“But,
Doctor, I
just can't
swallow a
lot of
tablets”

“Little mother, just
ONE
BONADOXIN®
tablet stops morning sickness
(you take it at bedtime)”



The formula tells why BONADOXIN quickly stops nausea and vomiting of pregnancy in 9 out of 10 cases.* Each tiny BONADOXIN tablet contains: Meclizine HCl (25 mg.) for antinauseant action / Pyridoxine HCl (50 mg.) for metabolic replacement. More than 60,000,000 tablets prescribed and taken. Toxicity low, tolerance excellent. In bottles of 25 and 100. Usual dose: one tablet at bedtime; severe cases may require another on arising. See PDR, p. 779.

BONADOXIN also effectively relieves nausea and vomiting associated with: anesthesia, radiation sickness, Meniere's syndrome, labyrinthitis, cerebral arteriosclerosis and motion sickness.

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For infant colic, try antispasmodic BONADOXIN Drops... stop colic in 7 out of 8 cases.*

Each cc. contains:
Meclizine 8.33 mg. / Pyridoxine 16.67 mg.

See PDR, p. 779.

*Bibliography available on request.



New York 17, New York • Division, Chas. Pfizer & Co., Inc. • Science for the World's Well-Being

Washington Roundup

News from the Nation's Capital of Interest to Physicians; Developments in Medical and Health Fields

Bureau of Labor Statistics reports medical care services price index increased 1.2 per cent between March and June, continuing an upward spiral that has been in progress since 1949. Latest figure brings index to 156.1.

* * *

Subcommittee of House Commerce Committee approved a bill by Congressman Schenck, Dayton, Ohio, to compel auto makers to equip cars with device to bring exhaust fumes within safety margin, but main committee amended measure to merely authorize a study of the subject.

* * *

A do-it-yourself first-aid kit developed at Gunter Air Force Base for use in area hit by atomic or hydrogen bomb has received high praise by military higher-ups as an efficient way of handling mass casualties.

* * *

Ohio State University was recipient of six cancer detection study contracts totaling \$179,850 awarded in July by Public Health Service.

* * *

Appointments of interest to Ohio physicians include selection of Dr. David E. Quinn as manager of Crile VA Hospital in Cleveland and addition of J. Harold Slater, formerly a staff assistant to Republican Congressional Committee, to AMA Washington office force.

* * *

National Institute of Health, Bethesda, Maryland, wants physicians to refer patients to assist the institute in its studies of Sjogren's syndrome and malignant carcinoid.

* * *

Publicity financed construction of hospitals and institutions for first six months of 1959 was up 19 per cent (total of \$211 million) over same period in 1958. Privately supported construction for same period, amounting to \$275 million, was off 9 per cent.

* * *

National Health Survey's comparative statistics on work time loss due to sickness and injury in year ending June 30, 1958, showed workers with family incomes under \$2,000 a year lost 10.3

days, compared with 5.9 days in \$7,000 and over group. Age-wise, plus-65 years group lost 11 days, while 17-44 group was 6.3 days.

* * *

An Ohioan, Dr. James L. Goddard, 36, has been named Civil Air Surgeon for Federal Aviation Agency, one of the most important medical positions in the Federal government. He leaves the USPHS where for three years he has headed its accident prevention program. He is a graduate of the George Washington University School of Medicine.

* * *

Federal program of grants and stipends to stimulate advanced training in public health and professional nursing has been extended by Congress to 1964. Program originally was to terminate June 30 of this year.

* * *

Question of licensing pilots who require medication for control of diabetes still is being weighed by the Civil Aeronautics Board.

* * *

Public Health Service has announced competitive examinations for physicians, occupational therapists, clinical psychologists and sanitary engineers at various points in country, November 17-20, inclusive. Application forms are available from USPHS, Washington, D. C.

* * *

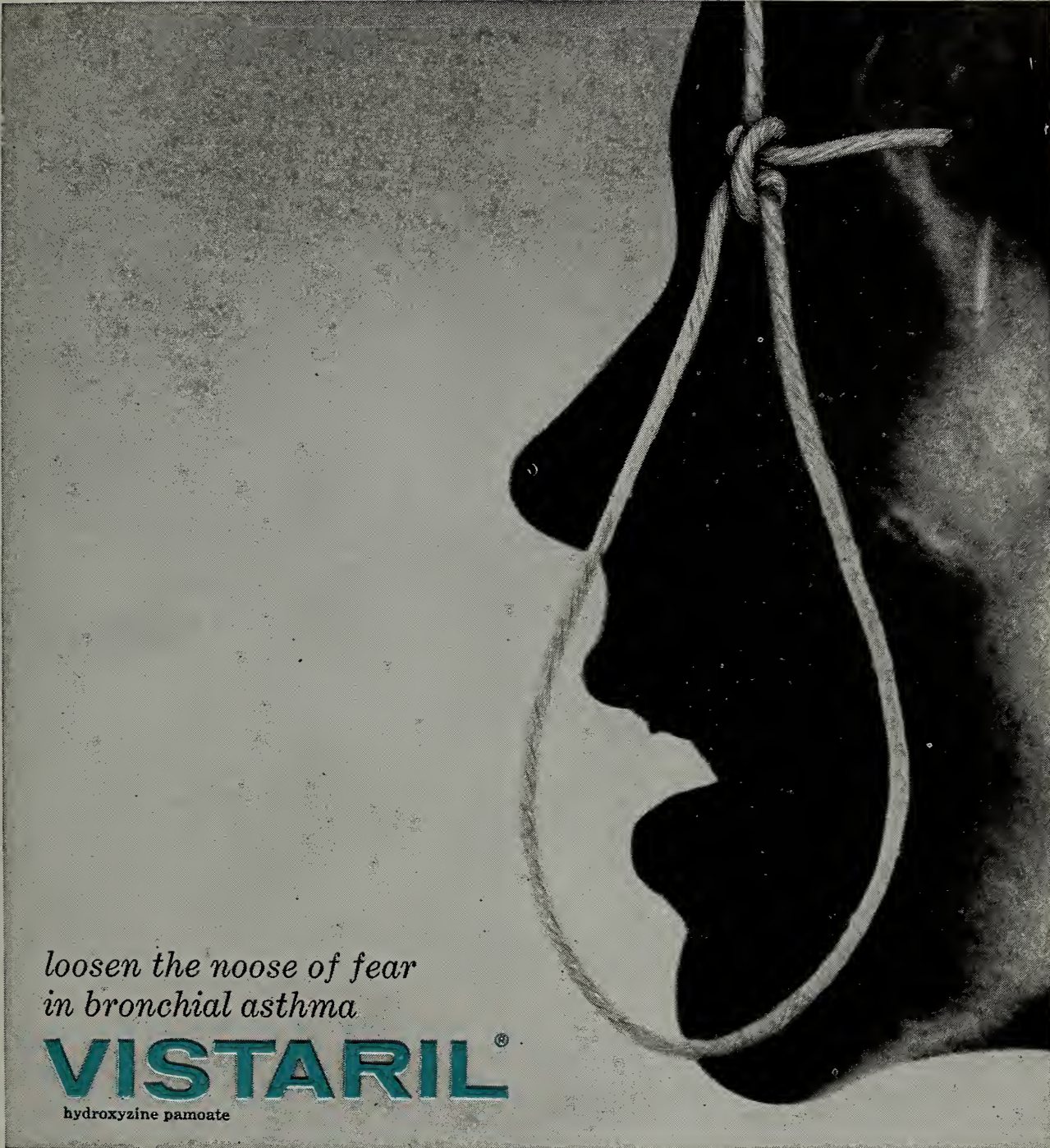
"Research In CBR," a new pamphlet on development in chemical, biological and radiological agents employable by belligerents and comparison of U. S. and Russia on this subject, has been issued by House Committee on Science and Astronautics and may be obtained from committee.

* * *

Senator Wayne Morse of Oregon in a floor speech has dared the AMA to try to defeat him in 1962 because of his active support of Forand Bill type legislation and has imputed commercialism to American physicians' opposition to the subject.

* * *

First Air Force officer to head the Armed Forces Institute of Pathology is Col. Frank M. Townsend, a Texan, experienced in aviation pathology.



*loosen the noose of fear
in bronchial asthma*

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hydroxyzine pamoate

...unties the mental and physical knot • tranquilizes anxious asthmatics • relieves apprehension • relaxes muscular tension • supplements anti-asthmatic medication

Vistaril was designated as a psychotherapeutic antihistamine by the A.M.A. Council on Drugs in 1958. A professional information booklet providing complete details on Vistaril is available on request.

Suggested oral dosage — adjust according to response: Adults, 50 mg. q.i.d., initially. Children over 6, 50-100 mg. daily in divided doses. Children under 6, 50 mg. daily in divided doses.

Supplied as Capsules — 25, 50, and 100 mg.; bottles of 100 and 500.

Oral Suspension — 25 mg. per teaspoonful (5 cc.); 1 pint bottles.

Parenteral Solution (as the HCl) — 25 mg. per cc.; 10-cc. vials and 2-cc. Steraject[®] Cartridges.



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In Our Opinion:

CHECK ON OSMA GROUP LIFE PLAN BEFORE YOU BUY

You may have read an article in the recent issue of a medical magazine telling how doctors can buy individual life insurance at group rates and intimating that the coverage offered by the particular kind of plan described offers something super-duper to the professional man.

Before you get all het up about life insurance plans you may have read about here and there, take a look at the plan which is offered members by the Ohio State Medical Association.

In the opinion of insurance authorities, the OSMA group life insurance plan ranks with the best and is superior to many other plans on the market in many phases of coverage.

Better not overlook this good bet!

If you do not have coverage in the OSMA plan and are interested in finding out about it, write to Turner and Shepard, Inc., 20 S. Third Street, Columbus 15, the authorized agency for the OSMA group life plan.

ACCIDENT PRONE MYTH ABOUT DISABLED WORKER DISPELLED

A recent incident offers dramatic proof that employment of the physically and mentally disabled does not constitute a greater physical risk to the disabled employee nor a greater financial risk to the employer than does employment of the non-disabled.

The State Bureau of Vocational Rehabilitation in an effort to determine whether and to what extent employment of the physically and mentally disabled constitutes a major compensation risk, asked the Bureau of Workmen's Compensation for its experience with subsequent or "second injury" claims from the inception of the statute to the present time.

The statute became effective in 1955 and was amended by the legislature in 1957. Briefly stated, it provides that if a registered handicapped employee is injured, disabled or dies as a result of an occupational injury or disease aggravated or caused by his pre-existing disability, subsequent benefits and costs are paid, in whole or in part, from a statutory surplus fund not affecting the employer's premium contribution rate.

The following amazing data were revealed:

Approximately 2,700 Ohio employers have taken advantage of this law by registering the

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

names of 74,070 disabled employees with the Industrial Commission.

The study shows that during this period—over three years—only 67 awards have been made by the Bureau of Workmen's Compensation to registered disabled employees or their families. This shows that only nine one-hundredths of one per cent of known disabled employees were involved in compensable industrial accidents which aggravated or were caused by their disabilities during that period.

Commenting the Bureau of Vocational Rehabilitation said: "It certainly dispels the myth that the disabled are 'accident prone' and that extreme caution and constant supervision must be exercised in their employment. We believe you will find employment of the physically and mentally disabled to be good business. The vocationally rehabilitated worker—on the right job—is no longer handicapped."

This information is of extreme value to physicians for the reason that they can be of great assistance to the disabled in finding suitable employment by acting as their "friend at court" in their contacts with potential employers. The data revealed by the study can be used by the physician in backing up his plea in behalf of the handicapped person who is seeking work.

DIVISION OF INCOME IN GROUP PRACTICE

Is there an ethical question involved in division of income of physicians practicing in a group? What about the ban on splitting of fees?

AMA Judicial Council has just issued a revised policy ruling on this subject. It reads as follows:

"The division of income among members of a group, practicing jointly or in partnership, may be determined by the members of the group and may be based on the value of the professional medical services performed by the member and his other services and contributions to the group."

HERE'S HUNCH IF YOU'RE TAKING CARE OF ATHLETES

Many, many physicians these days are asked to help the local schools on matters relating to the health and medical care of boys and girls engaged in athletic activities. This is as it should be as physicians are best able to advise and act on such matters. Nevertheless, the physician has

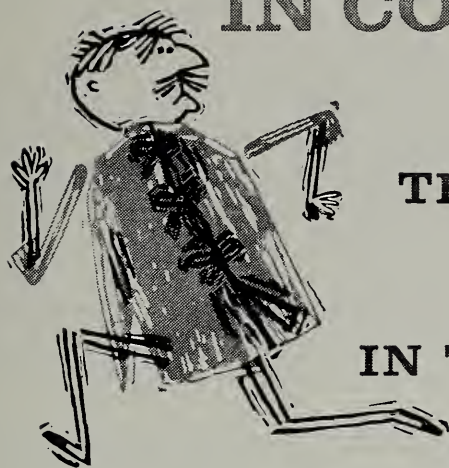
IN CONSTIPATION

ELIMINATE

THE ENEMA AT

HOME OR

IN THE HOSPITAL



"The effectiveness of the senna preparation ['Senokot'] in reducing the need for enemas...is clearly apparent..."

Kasdon, S. C., Morentin, B. O.: J. Internat. Coll. Surgeons 31:455 (Apr.) 1959.

...time and time again, gentle, natural acting 'Senokot' is cited in clinical reports as the therapy of choice in all patients with acute or chronic constipation.

'Senokot' acts uniquely, through neuro-stimulation of Auerbach's plexus in the colon, duplicating the process of normal defecation.

When therapy with 'Senokot' is substituted for enemas the difference is safe, natural physiologic correction of constipation, and increased patient comfort, as well as significant saving of time for your hospital's nursing staff.

THE EFFECTIVENESS AND SAFETY OF THE DOUBLY STANDARDIZED SENNA CONCENTRATE CONTINUE TO BE DOCUMENTED BY CLINICAL AND LABORATORY INVESTIGATIONS WHICH CONSTITUTE THE FASTEST GROWING BIBLIOGRAPHY* ON CONSTIPATION CORRECTION

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to be on his toes and have up-to-date knowledge in order to do the right kind of a job.

Therefore, it is suggested that physicians working with the athletic departments of local schools familiarize themselves with the new pamphlet, "Safeguarding the Health of the High School Athlete" being distributed by the AMA Committee on Injury in Sports and the National Federation of State High School Athletic Associations.

The pamphlet is a check list to help physicians evaluate five major factors in health supervision of young athletes: Proper conditioning, careful coaching, good officiating, right equipment and facilities, and adequate medical care.

If you want a copy, write the OSMA Columbus Office and it will fill your request.

ARE YOU PROPERLY REPRESENTED IN UNITED FUND ACTIVITIES?

The Summit County Medical Society has asked the Akron United Fund for greater representation from the medical profession on its executive committee for the reason that more and more of the UF's activities are in the field of medicine-health.

We agree thoroughly and recommend that other county medical societies take a look at the situation in their areas.

At the same time, when such a request is made the medical profession must be ready to back it up with action—not just promises. The profession must see to it that those named on UF boards attend meetings; carry their share of the workload; and take a constructive and objective attitude.

In our opinion an editorial in the *Akron Beacon-Journal*, reading as follows, summarizes the situation quite well and offers good advice to both the UF and medical profession on the subject:

"The Medical Society's request that four doctors be named to the United Fund Executive Committee is one that should be granted quickly—lest the society change its mind.

"In his letter presenting the request for additional representation on the UF governing board, Dr. Donald Minnig, society president, pointed out that at least one-fourth of the UF agencies have medical functions. The significance of this observation will be readily apparent to the UF executive body.

"Health agencies usually have doctors on their boards—doctors who, as a rule, are so pre-occupied with the particular disease which the agency is designed to combat that they have lost their community perspective. In dealing with these agencies the executive committee would be greatly strengthened if its membership included

several physicians, and preferably physicians who can be objective in viewing the community's needs.

"Such physicians have been invaluable to the UF executive committee in the past, but there never have been more than two—or at the most, three—of them on the committee at the same time.

"Knowing that doctors are busier than most people, the UF has tried to avoid imposing on their time. The society's letter should be welcomed as a sign that the medical profession is willing to contribute more time and talent to the administration of UF affairs than has been asked of it up to now.

"Whether four doctors is the right number, we can't say, but we're sure both the UF and the profession will benefit from greater doctor representation on the executive committee."

BEWARE OF QUICK COURSES IN HYPNOSIS

Better think long and hard before you take any of the so-called "quick courses" in hypnosis, given by some traveling teacher, through correspondence, or at a private school of hypnosis.

In the first place, such courses may not constitute adequate training for the physician who wants to use hypnosis in his practice.

Secondly, the legal aspects should be considered. Unless the physician using hypnosis is properly trained he can run into some tough legal situations. The matter is so new that there are few legal guidelines as yet.

To protect himself, the physician wanting to use hypnosis in his practice should get his instruction under responsible medical direction, which will emphasize the limitations of hypnosis as well as its indications.

GIVE YOUR LOCAL JAYCEES YOUR ACTIVE ASSISTANCE

We see by the papers that the National Junior Chamber of Commerce's activities committee has stated that health subjects and problems should be stressed by the organization during 1959-60.

Naturally, this puts a challenge to the County Medical Society of any area where there is a Junior Chamber of Commerce.

It is suggested that the proper official or committee chairman of any County Medical Society in Ohio immediately get in touch with the local Junior Chamber of Commerce, if any, and offer assistance in promoting that organization's activities in the field of medicine-health.

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carry her through term to the
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This means you are assured of a
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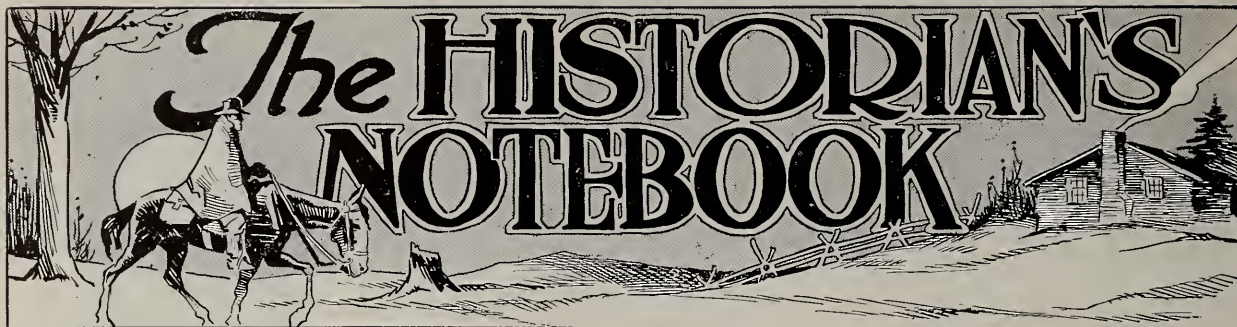


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A Short History of Medicine and the Physicians Of Delaware County, Ohio

M. S. CHERINGTON, M. D.

PART II

(Continued from August Issue)

AT THE REORGANIZATION of the Delaware County Medical Society in 1868 Dr. Blymyer was elected president, Dr. P. Willis vice-president, Dr. E. H. Hyatt, secretary and Dr. J. M. Cherry, treasurer. Others present were Drs. T. B. Williams, W. T. Constant, William McIntyre, John A. Little, J. H. White, Henry Besse, Calvin Welch, John A. Carothers, Joseph McCann, and A. E. Westbrook. In 1869 Dr. Blymyer was reelected president and at the close of his term he gave a grand banquet to his colleagues. So far as we can learn Dr. Blymyer, in 1869, Dr. Dorrance E. Hughes, in 1907, and Dr. A. E. Westbrook, Ashley, were the only ones to remember the society with such honor.

Harmony and good feeling prevailed for many years when some disturbing element put an end to it. Many reorganizations took place but did not last. After some 15 years of inactivity a new organization was effected and has continued in good form to this present time. In 1904, all schools of medicine of the county were invited under the broad plan of "charity to all" to become active members.

In the very early day of our pioneer settlements the few white doctors had little more to use in treating the diseases they were confronted with than did the Indians, and many times the Indians could do it better as they had had many years of experience with them. The most serious diseases met with were: Malaria, which was largely controlled by the drainage of the swamps and the introduction of quinine; Remittant Fever was at first confused with malaria, but when the

The Author

● Dr. Cherington, Delaware, is a member of the staff of Jane M. Case Hospital.

quinine failed to give relief they then resorted to calomel with some success; Cholera was met with several times as it swept up the river valley and into the tributaries; Milk Sickness—This was a new disease to the doctors and affected cattle as well as man. It was probably due to a poisonous weed and was transmitted to man through milk or from unclean vessels.

In reviewing some of the physicians of the early days, we will take the first few in the order of their coming into the county. It is not known who might have taken care of the small number of people here from the time of the Carpenter settlement until the coming of Dr. Lamb. We do know that at Worthington Col. Kilbourn, though not a doctor, did do much to care for the sick of his settlement.

First Physician in County

DR. REUBEN LAMB, was the first physician in this area. Colonel James Kilbourne first came out to Worthington in 1802 and the next year saw six men settled there who were members of the Scioto Land Company. He may have been influential in persuading Moses Byxbe to come out and occupy his lands in what is now Delaware County.

Dr. Lamb was born in Chenango County, New York, in 1774. He is said to have read medicine there before 1806 but we do not know if

Presented before the Delaware County Historical Society April 27, 1959.

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respond quickly and routinely to*

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MUCH MORE ACTIVE ANTIEMETIC effect per milligram dosage than with other phenothiazines

MINUS the danger of significant hypotensive reaction

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(e.g., digitalis, nitrogen mustard, aminophylline)

TOXICOSIS

(e.g., uremia, diabetic acidosis, leukemia, carcinomatosis)

MORNING SICKNESS

HYPEREMESIS GRAVIDARUM

OPERATIVE PROCEDURES

MENIERE'S SYNDROME

RADIATION SICKNESS

PSYCHOGENIC PHENOMENA

S-273

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he had any formal medical education; however, he was well prepared.

In the fall of 1805 he resolved to go to Pittsburgh and down the Ohio and Mississippi Rivers to New Orleans. However, at Pittsburgh or on his way down the Ohio, he fell in with Col. Moses Byxbe who persuaded him to go with them to Worthington on the Scioto and on north to Berkshire on Alum Creek.

Worthington was already a well known town and business center in this area. After a few months residence in Berkshire, Dr. Lamb moved to Worthington. The town had no physician and gave more promise for the future. Soon after locating there Dr. Lamb married Miss Mary Sloper, May 6, 1806. She lived only a short time and on September 13, 1807 he married her sister, Miss Cynthia Sloper. A few years afterward they moved to Illinois, to the town of Galesburg. The doctor, we presume, practiced medicine there. After a few months his wife died of fever and he at once returned to Worthington.

Helped Lay Out the Town

In the spring of 1808 Dr. Lamb joined his old friend Col. Byxbe and they laid out the town of Delaware. There is great confusion about his marriages as to whom and the dates. It is stated that he was married three times but it may have been more. The 1880 history gives it as four. His oldest son was born in 1807 and was long a resident of Delaware.

The Lytle history states that Dr. Lamb first married a Miss Campbell of Worthington and that after her death he married a Miss Sloper of Delaware in 1815. They then moved to Illinois. The following year she died and he at once returned to Delaware, and soon after married Mrs. Platt, a sister of his last wife. Dr. Lamb was about 35 years old when he began his work in the county and because of ill health, in 1822 he moved to Missouri where his wife died in less than a year and he returned to Delaware, but did not resume an active practice as before. He died in 1850 and we are told that he left a widow—his fourth wife, at least.

Dr. Lamb possessed great energy and mental force. He had the credit of being a man of ability and a most competent practitioner and surgeon, besides being very well liked.

His energy and ability called him to many vocations. He assisted in organizing the county and town and in organizing and conducting various business enterprises. He was the first recorder of public records, and the first physician of the county and city, and was called upon to

serve a wide area in that capacity. Col. Byxbe erected for him a log cabin, for a home and an office on the corner of East William and North Union Streets on the lot Byxbe owned and where later stood the residence of Hon. J. C. Evans and still later and today the Sarah Moore Home. He lived there briefly, perhaps only a year, when he built for himself on South Union Street and on the banks of the Delaware Run, a palatial cabin that stood on the ground in the rear of where Martin Miller's residence stood in 1880.

Dr. Lamb worked hard during these first years and was called upon to ride great distances to attend the sick. He perhaps was subjected to more exposure and danger in traveling over the tractless wilds, in the night and in all sorts of weather, and confronted by the wild animals and the Indians, than was anyone else there. There were no roads, merely trails or "cutouts" and there were no bridges to cross the streams. Often he would be alone but at times would be accompanied by the messenger who had come for him.

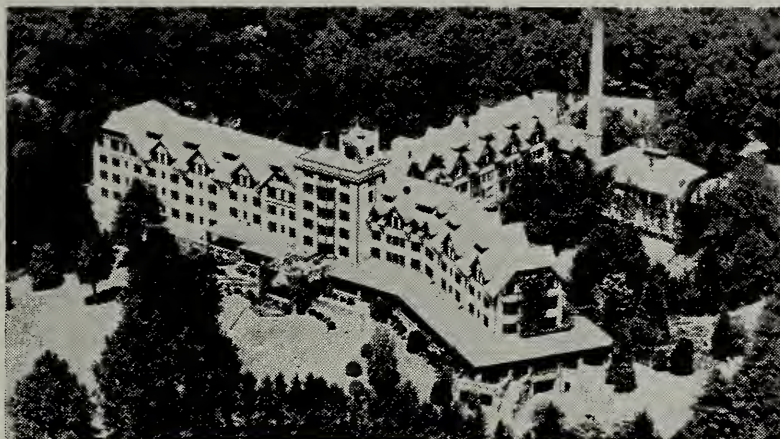
Surgical Instruments Scarce

From physical disability he was required to quit this very active practice and confine his work to office practice, the preparation of medicines and consultation. The types of diseases that he met with in the West materially differed from those he met with in the East, his homeland. He was acknowledged by all to be skilled and successful in dealing with the diseases of the new country. He disliked surgery, but he was the only one who had any instruments in the county at that time. He freely loaned them to all practitioners who had occasion to use them. He was a man of few words and scorned and hated bluff and sham and ignorance in the profession. He was always sympathetic and affectionate, but quiet, socially and professionally.

The old physicians were wont to tell a good story on Dr. Lamb. In his early practice, about 1818, a Mr. Shippy was taken sick at the home of a prominent citizen, Col. Sydney Moore. When the crisis of the disease had come, two watchers were engaged, but one failed to put in an appearance. The doctor made his last visit for the night, gave careful and positive instructions to the nurse and left. The man seated himself comfortably before the fire to await the coming of his associate. Weary from his day's labor, he soon forgot his vigil and fell into a deep sleep. Together, the nurse and the patient, traveled in the land of dreams. When the nurse awoke, the beautiful sunshine was streaming into the room. Frightened beyond measure and fearing

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lest the patient be dead from neglect, he walked silently to the bed. To his great amazement and joy, the patient turned over, rubbed his eyes, stretched his arms, and was equally surprised to learn that it was morning. He spoke of having had a good night's rest and of feeling much better, and so did the nurse.

The good doctor soon arrived and going to his patient, pronounced him out of danger, and highly complimented the efficient nurse, remarking that in the future he would know upon whom to call to watch and nurse and give the medicine to his sick. The patient lived for many years. As stated before, Dr. Lamb died in 1850 at the age of 76, having lived here most of 43 years.

Dr. Lamb was not left alone long to endure the arduous duties in the wilderness for in 1809 DR. NOAH SPAULDING, a graduate in medicine and literature at old Dartmouth College, and a native of New Hampshire, settled in Berkshire. He remained there but a short time as he saw that Delaware was going to be a city of more promise and so in a year or two he moved there. He had good knowledge and was very cultured. He was slow in expression, but exact in his statements, exceedingly amiable, social and cheerful. He was perfectly temperate in all of his habits.

The Human Touch

Dr. Spaulding was not long in gaining a good practice among all classes. He was noted as a delightful story teller, and with his feet high above his head he would entertain his listeners with pleasing and wholesome stories. He remained in Delaware until his death in 1832. Dr. Spaulding was a member of the Protestant Episcopal Church and a most exemplary Christian. He was also a fine singer, and taught classes in singing. He left his imprint upon the community for many years.

In 1818 he assisted in organizing the first Sunday School in the county. His scholarly qualifications secured his appointment as a member of the board of county examiners for teachers. He made a pleasing impression on one of Delaware county's greatest and most noted physicians, Dr. Ralph Hills. When a mere youth medical profession was rapid and he grew into Hills came before the board for examination for credentials to teach school. Suddenly Dr. Spaulding turned to the young man and said "Ralph, what is the difference between six dozen and a half dozen dozen." The answer being promptly given the Doctor turned to his associates and said "You may as well write out his certificate.

He is one of Dr. James Hills' sons and we know what *he* is."

There is a joke handed down about Dr. Spaulding. It seems he had not the most explicit confidence in his own professional judgment. One day he met Dr. Lamb on the street and said "Doctor, I have given my wife some blue pills, and they have not acted as they should, see what you think of them," showing some he had in his hand. Dr. Lamb examined them, placed one between his teeth and then remarked: "These are buckshot and made of lead."

The third doctor to locate in the county was DR. N. HAWLEY. He came to the well advertised field of attraction, Berkshire, in 1810 or 1812, from what place is not known, and about whom traditional history fails to tell anything. His remarkable energy, shrewdness and great skill gave him his share of the work in the new land. He also was armed with pleasing anecdotes and attractive stories which entertained his numerous friends. He died in 1822. He was advanced in years when he came to Berkshire and was known as "Old Dr. Hawley" from the beginning.

Misfortune Takes Its Toll

DR. SILAS MCCLARY, the fourth doctor to settle in the county, in 1813 came to Berkshire, where all seemed to settle first. After 20 years of labor there he moved to Delaware and in a short time went to Radnor, where he died. He, we think, was the first doctor to settle in Radnor. In his earlier days he was quite successful in business but in later life misfortune came upon him and he was left destitute and uncared for when he died. Some traits of his character always prevented him from becoming a favorite or friend of members of the profession and his services were seldom sought after by them.

DR. SAMUEL MOULTON, was the fifth physician to take up his work here and he came directly to Delaware, thus slighting Old Berkshire, in 1819. He came from Rutland, Vermont, where he graduated in medicine. His rise in the great favor and into an extensive practice. Dr. Moulton was well read, skillful, and made few mistakes. Dr. Lamb esteemed him highly for his learning and gentlemanly qualities and often sought his council. The "White Plague" or tuberculosis cut his brilliant career short and he died in 1821, or '22, at the age of 29 years. For many years his name was kept green among the people in this locality by Dr. Lamb and others prescribing and using "Dr. Moulton's Cathartic Pills."

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Occupational Cancer

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Historical

OUR KNOWLEDGE of cancer of occupational origin dates from 1775. In that year, when this country was occupied with more cogent matters, Percivall Pott described in words that belonged to a more elegant generation a disease peculiar to chimney sweeps, which, as he put it, "always makes its first attack on, and its first appearance in, the inferior part of the scrotum, where . . . it pervades the skin, dartos, and membranes of the scrotum, and seizes the testicle which it enlarges, hardens, and renders truly and thoroughly distempered; from whence it makes its way up the spermatic process into the abdomen, most frequently indurating, and spoiling the inguinal glands; when arrived within the abdomen, it affects some of the viscera, and then soon becomes painfully destructive." With these words, Pott, whose name has been preserved more vividly in the orthopedic fields, described the first recorded instance of occupational cancer, of a type which in the 1920's still produced nearly 10 per cent of the cases of scrotal cancer in England.

In 1794 came the next step when Benjamin Bell observed that scrotal cancer from soot could develop in persons who were not chimney-sweeps; and in 1882, a further occupation was involved when Paris, in findings that have never been confirmed, incriminated arsenic as the cause of skin cancer in the copper smelting and tin refining industry.

In 1875, scrotal carcinoma from a different

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source was observed by Volkmann in Germany, who described three cases among workers engaged in separating paraffin from coal distillation, and four years later a new clinical field was entered when Härting and Hesse reported the controversial Schneeberg cancer of the lung, the symptoms of which had perhaps been described by Paracelsus 350 years previously (1531).

By the turn of the century several other occupational cancers had been described or speculated upon. Unna, in 1894, suggested that the hyperkeratotic and malignant skin lesions of sailors were due to excessive exposure to the sun, and in 1895 came the first description by Rehn of bladder cancer in the dye industry. X-ray was incriminated early in its development when Friebe described resulting skin cancer in 1906, and the effects of ionizing radiation were again recognized when Maitland found bone sarcomas in radium dial painters in 1929.

Still other industries began to be involved, chromates, for examples, being suggested as a cause of lung cancer by Pfeil in 1911 and confirmed by Machle years later, while in 1932 Grenfell found lung and sinus cancer in certain nickel workers, and three years later Lynch and Smith reported a high incidence in asbestos workers. Further, as a puzzling entity, Weil reported paranasal sinus cancer from isopropyl alcohol in 1952.

These are by no means all of the cancers whose origin has been attributed to occupation. Legal files are filled with allegations of cancer produced by a single trauma. It has been suggested that exposure to carbon tetrachloride in the dry cleaning industry leads to cirrhosis with a high incidence of hepatoma. Leukemia has been blamed on benzene and on x-ray exposure. Rubber has been suggested as a cause of brain tumors, etc. However, these latter suggestions would appear to have been based more on a dubiously founded theory of proximate cause, than on a critical and adequate review of the data. Nevertheless it is evident that occupational cancer exists, and before we can prevent it or protect against it, it behooves us to learn how many varieties there are, to observe where they occur, and to define the etiology as precisely as possible.

Eckhardt's recent book *Industrial Carcinogens* states that of the cancers proved to be of occupational origin, 75 per cent involve the skin, 15 per cent occur in the bladder and 10 per cent occur in lung, bone, paranasal sinuses and larynx.

Skin

Of the 75 per cent of occupational cancer involving the skin Eckhardt states that 60 per cent comes from exposure to coal tars and 36 per cent from exposure to shale oil.

Hydrocarbons: The early studies in England presented a confusing picture because scrotal cancer occurred in apparently unrelated occupational groups: Chimney-sweeps, mule spinners in cotton mills, the coal gas industry and Scottish shale pits.

To complicate the problem of correlation of these apparently unconnected occurrences numerous other factors were found to enter the picture, such as:

a. The susceptibility to the development of skin cancer appeared to vary from individual to individual;

b. The time of exposure required for its development appeared to vary from as little as four months in the case of bituminous shales to as much as 50 years in the case of British lubricating oils;

c. In some individuals the appearance of skin cancer would not manifest itself until long after exposure ceased.

As a further complication it was discovered that the carcinogenicity of these substances appeared to vary with their geographical source, the European, Middle and Far Eastern oils and tars being more carcinogenic than the American, and the Scottish shale oils being more carcinogenic than the other European.

Consequently inquiries carried out in the earlier days in Europe and the U. S. A. on the basis of the English reports showed a relatively low incidence of skin cancer from these substances. Thus, because of the interplay of many different factors it took some little time before the common factors were observed in soot, pitch, tar, mineral oil, and various petroleum tar distillates.

With the discovery by Yamagiwa and Ichikawa in Japan in 1915 that cancer could be produced in animals by prolonged inunction with coal tar, a great step forward was made; and in 1928, Twort and Ing published the results of their investigation into the carcinogenicity of various lubricating oils, showing that while sperm oils were harmless, petroleum oils possessed some carcinogenicity and Scottish shale oil was twelve times as dangerous as the petroleum oils. They also observed that the hazard of the petroleum oils varied with the boiling point of the fraction, the higher boiling series being greater than the low.

The greatest advance, however, came in the 1930's when Shear and Andervont,¹⁶ while investigating the polycyclic hydrocarbons, discovered that the synthetic substance 1, 2, 5, 6-dibenzanthracene was carcinogenic, while Cook, Hewett, and Hieger went on to isolate from carcinogenic coal tar the related substances 3, 4-benzpyrene, and methylcholanthracene which they also showed to be carcinogenic, the former being considerably more potent than the dibenzanthracene. Kennaway, in England, went on to demonstrate that carcinogenic activity was not restricted to the polynuclear aromatic hydrocarbons but was shared by other substances such as the benzacridines, benzocarbazoles, the aminostilbenes, the aminophenyls and numerous other compounds.

The carcinogenic subclasses of polynuclear hydrocarbons can, however, be clearly related to their parent substance phenanthrene. The evidence indicates that the carcinogens so developed may combine with cellular substrates in the body and lead either directly or indirectly to the elimination of certain key proteins or enzyme-proteins essential in the regulation of normal growth.⁹

How then do we fare today in the occurrence of occupational skin cancer from oil or tars? It

is, of course, relatively more common in England and Europe than in the United States, Heller¹⁰ showing in a study he carried out for the Rockefeller Foundation that the incidence here is rare. Cases, however, continue to occur throughout the world, the highest incidence arising in workers with cutting oils whose constituents, namely animal, vegetable, and mineral oil with added agents, vary widely accordingly to use. The active agents in cutting oils of mineral origin, nevertheless, have been shown to be the now familiar 3, 4-benzopyrene, and 9, 10-dimethyl-1, 2-benzanthracene, and consequently a degree of hazard continues to exist that warrants a continuing drive to have such oils replaced by inert materials.⁸

In the coal gas industry, which fortunately is uncommon in this country, and in the shale oil industry, nearly 4,000 cases had been reported in England by the middle of this century, and of those cases of occupational skin cancer that have occurred in this country approximately 70 per cent have been associated with the handling of gas-works tar and pitch.

In the petroleum industry, however, a greater danger arises—that from the “so-called” “slack waxes” that remain after the processing of paraffin wax, in wax or paraffin presses. These have been shown to contain some unsaturated aromatic hydrocarbons which can be highly carcinogenic, and on occasion have given rise to a clinical lesion. In addition, some of the aromatic components of high-boiling fractions of petroleum have been shown to be carcinogenic, as have some of the tars prepared from petroleum by catalytic cracking processes. Fortunately, the degree of carcinogenicity of the latter is by no means as great as that of a high temperature coal tar.

Eckhardt²⁰ states that 60 per cent of occupational skin cancer comes from exposure to coal tars, and 36 per cent from exposure to shale oil. Today, knowing much about the where, when and why of these occupational skin cancers, prevention is now possible.

Arsenic: We know far less about the other 4 per cent of occupational skin cancer. Arsenic was incriminated as a carcinogen in 1887 by Jonathan Hutchison whose opinion has been confirmed to a limited extent by others. Arsenic is now regarded as a cancer-auxetic, i. e. a substance which provokes changes in epithelial cells predisposing towards cancerous change. The occurrence of carcinoma associated with exposure to arsenic has been observed particularly in the manufacture and use of sheep dip, where a squamous cell carcinoma may be produced after many years of exposure. It has in addition been noted after prolonged medicinal treatment and has been

shown in Europe to occur from the constant presence of arsenical dust on the skin. Fortunately, as with other occupational skin cancers, prompt excision is usually effective, and can be prevented by scrupulous attention to the personal hygiene of workers so exposed.

Nitrates: As far as other inorganic compounds are concerned the nitrates have been reported in Chile as a source of occupational skin cancer by Prunés¹⁵ who describes a hyperkeratosis which after 10 to 30 years may undergo carcinomatous change. However, since only 17 cases have occurred among 30,000 workers over a 9 to 10 year period in Chile, further evaluation of this agent as a carcinogenic material is indicated.

Physical Agents: The best known physical agent implicated in carcinogenicity is ionizing radiation. The effects and dangers of radiant energy from x-ray and radioactive compounds are well known. It should be remembered that in addition to the therapeutic use of such agents, with consequent exposure of both patient and therapist, there is an increasing use of powerful radioactive sources in industry for such purposes as inspection of manufactured parts, tagging of compounds with radioactive isotopes, manufacture of luminous paints, oil surveys, etc. Thus there is an increasing risk of exposure which, if prolonged, might give rise in some cases to malignant change.

In the early days of investigation into the effects of radiation numerous instances of malignant change developed in the skin following dermatitis or ulceration, with occasionally the development of osteogenic sarcoma following exposure to ingested internal emitters in addition to the more common effects of excessive exposure. But as the hazards were slowly recognized the subsequent precautions which were devised slowly reduced the incidence of malignancy to a negligible amount. However, the danger still exists, and in the perhaps less rigidly controlled industrial situation the potential danger becomes all the greater.

Both heat and ultraviolet light have been blamed for skin cancer, but in neither instance has there ever been proof that the incidence of skin malignancy among employees with such exposure exceeds that in the general population relatively free of such exposures. Local trauma of a continuing nature, such as the rubbing of a basket or hod on a particular part certainly predisposes to or causes cancer at the site in a very limited segment of the world's population.

Bladder

The history of occupational carcinoma of the bladder dates back to the origin of the German synthetic dye industry in the latter part of the

last century, when the accidental discovery of the dye, magenta, led to the development of the vast complex that constitutes the present-day chemical industry. The condition was first observed by Rehn in 1895, who demonstrated to his skeptical colleagues the occurrence of bladder carcinoma in a series of dye workers. The causal agent he considered to be aniline, a view that was held for many years, although more recently it has been conclusively shown that pure aniline in itself is noncarcinogenic, although it may in an apparently pure state be contaminated with carcinogenic materials.

For some time after the initial discovery the reports of these tumors were confined to Germany, but with the expansion of the British synthetic dye industry during World War I cases began to appear in England in the 1920's, and by 1931 what would appear to be the first American case was reported. Despite stringent precautions in the industry, tumors continued to occur, and in 1954, Case and his colleagues in a remarkable statistical study of mortality in England and Wales during the period 1921-1950 showed that the overall risk of death from bladder carcinoma in workers engaged in the manufacture of dyestuffs was 30 times that of the general population.^{5,6}

However, along with the development of the dye industry, research into the causal agent was proceeding in Germany, England and the U. S. A. and before long it was established that the aromatic compounds were those responsible. Numerous compounds were incriminated, including aniline, toluidine, xylydine, benzidine, the naphthylamines, etc., but of recent years it has become accepted that although other carcinogenic agents exist in the dye industry the naphthylamines, particularly the beta isomer, are the primary culprits.

Occupational carcinoma was first attributed to the naphthylamines in 1898, but after World War I beta-naphthylamine became accepted as the cause on epidemiological grounds, some 10 years before bladder tumors were produced by it in dogs by Hueper and Wolfe. Both the alpha and beta isomers are common dye intermediates, developed during synthesis of the various dyes, and beta-naphthylamine, at least, has been shown to be carcinogenic to animals. Some controversy exists over the carcinogenic properties of the alpha isomer which can be separated in its pure state from the beta only with considerable difficulty, but it is generally believed that any resulting carcinogenicity arises from associated beta-naphthylamine which may contaminate it up to 5 per cent.

The discovery of diazotization by Griess in

1858 led to the development of the azo dyes for which new aromatic bases, including the naphthylamines were required. Benzidine, chemically related to the azo dyes, and incriminated as a cause for many years by Maguigan, is known to be carcinogenic to rats and dogs, and has been conclusively shown in the statistical study of Case and his colleagues in England to produce a high incidence of bladder tumor in man.

The azo dyes themselves, although evincing no evidence of carcinogenicity in man, have been shown experimentally to be carcinogenic to animals—o-aminoazotoluene, and 4-dimethylaminoazobenzene (butter yellow) producing liver neoplasms in rats and mice, and bladder tumors in dogs. The aniline dyestuffs, auramine and magenta do not appear to be carcinogenic *per se*.¹⁸

The tumor which develops from the aromatic compounds in man is of relatively low grade, and its development is influenced to some extent by the age at which exposure begins, there being a slightly increased susceptibility in older men. It generally develops in those susceptible some 4 to 18 years (average—16 years) after initial exposure, the required duration of the latter being approximately one year.

As far as the mode of action on the genitourinary system is concerned, the compounds discussed above, although established carcinogens, do not appear to make their attack in the form in which they are absorbed. The action occurs within the bladder, renal pelvis, or ureter, and not via the blood stream, and appears to be affected by metabolites of the substances concerned. The effective carcinogens are probably hydroxy derivatives of the amines, to which man is highly susceptible. Since this susceptibility is not shared with the common experimental animals there is considerable difficulty in producing the tumor in the laboratory. There is some evidence that the urinary precursors of the ortho-hydroxy-amines are the glucuronic acid conjugates.⁷

Boyland³ has linked this ortho-hydroxy theory with the metabolism of tryptophan, and has shown that one of the metabolites of tryptophan, 3-hydroxy-anthranilic acid, which is greatly increased in bladder carcinoma, is itself highly carcinogenic, and suggests that this is the active causal agent in the occupational carcinoma of the bladder.

The dye industry, however, is not the only source of carcinogenic aromatic amines. In 1954, Walpole and others¹⁹ in England showed that the compound 4-aminodiphenyl, used in the manufacture of a rubber antioxidant, was a highly potent carcinogen, and shortly thereafter Melick¹⁴ and his colleagues in the United States showed that a high incidence of workers where this com-

pound was made from 1935 to 1955 developed bladder carcinoma, although the rubber antioxidant produced from it does not appear to be carcinogenic. In addition, another compound, 2-acetaminofluoride, used as a commercial insecticide has been shown to be carcinogenic.

Respiratory Tract

When considering occupational cancer of the respiratory system, which in this context includes the tract from the nose and paranasal sinuses to the alveoli, it is pertinent to observe that there has been a considerable overall increase in the incidence of lung cancer during the past 25 years. How much of this is due to improved diagnosis and greater frequency of autopsy and how much to atmospheric pollution, increased exposure to occupational carcinogens, and other as yet unknown factors can only be a matter of opinion. And, because of a paucity of experimental evidence that points conclusively to any specific compound, it has become more and more necessary in analyzing the occupational factor to rely on the results of the long-term controlled statistical study. However, much can be gained in this type of study and several compounds will be discussed that have been shown to be associated with a significantly increased incidence in cancer among those exposed to their hazards.

Chromium: Chromium compounds have long been known to produce chronic ulceration, dermatitis, and caustic effects, giving rise to the well known "chrome holes" (perforation of the nasal septum), chrome dermatitis, and chrome burns. These, however, are not followed by neoplastic change and it was originally thought that chromium had no carcinogenic properties. In 1936, however, some 25 cases of pulmonary carcinoma were recognized in Germany in men who produced chromates from chrome ores and residues, and in those who used chromates in tanning, plating and similar procedures.

Until 10 or 15 years ago there were few reports of cases outside Germany, but in 1948 Machle and his colleagues¹⁴ published a study of incidence in the five chromate-producing companies of the United States showing that the death rate from respiratory cancer in the chromate industry was 16 times higher than expected. They further showed that the incidence of nasal irritation did not parallel the incidence of lung carcinoma and that the incidence of lung carcinoma varied from plant to plant in populations that were otherwise similar. Investigating further they concluded that the difference in incidence lay in the nature of the compounds handled and consequently suggested that the monochromates may be the compounds

responsible for carcinogenesis. On the other hand, Koven et al., suggest that acid-soluble, water-insoluble compounds in chromate ore are the etiologic agents. At this time one may conclude that the specific etiologic agent is not known.

In Britain also, the incidence appeared to be negligible until 1955, when Bidstrup and Case¹ showed in a statistical study that the incidence of lung carcinoma in chromate workers in the previous six years was four times greater than expected.

As with other occupational cancers, the latent or induction period may be very prolonged, often as much as 20 to 30 years, and in some instances the tumor has appeared long after exposure ceased.

Nickel: Nickel, which is known for its tendency to produce a sensitization dermatitis, has also been incriminated as a potent carcinogen. A significantly higher incidence of respiratory carcinoma has been shown to occur in workers in the nickel industry, the carcinoma chiefly affecting the mucous membranes of the nose and air sinuses, although sometimes found as a bronchial carcinoma. Several theories have been propounded to explain the occurrence of these tumors, all of them handicapped until recently by lack of experimental confirmation. The original theory that the responsible agent was a metallic arsenide formed from associated compounds has been discarded largely because of a total absence of any other evidence of arsenical poisoning.

The favored theory relates the occurrence to the Mond process of nickel preparation in which nickel carbonyl is heated to drive off the carbon monoxide and allow the deposit of finely divided nickel. It is suggested that thereafter the nickel carbonyl, which hydrolyzes in water to nickel and carbon monoxide, or finely divided elemental nickel, is inhaled and deposited at sites suitable for the production of the tumors. Although previously it has not been found possible to produce tumors in animals from nickel except by parenteral administration, this theory in 1958 found support from Hueper¹¹ who managed to produce adenocarcinoma in animals exposed to fine nickel dust.

Asbestos: There is no experimental evidence at this time to suggest that asbestos is carcinogenic in any form. It has been shown statistically in England, however, that there is a high incidence of lung cancer in asbestos workers known to be suffering from concurrent asbestosis, Doll in 1955 noting in a study of men who had worked 20 years or more in the asbestos industry that the incidence of lung carcinoma was 10 times that expected, while in the official statistics of the Chief Inspector of Factories and Workshops in

1955, 22 per cent of 222 men and 12 per cent of 143 women showed combined asbestosis and carcinoma.⁸ The induction period appears to be very long and the tumor is highly malignant.

Although claimed by some that any tumor from asbestos is the result of simple irritation, it has been observed by Bonser, Faulds and Stewart² that in the exposure of both the asbestos worker and the iron ore miner, in each of which a high incidence of pulmonary carcinoma is noted, there is a common factor of silica-induced fibrosis which in each case precedes tumor formation. They suggest that in the one situation fibrous asbestos, and in the other iron oxide, modify the action of silica such that the silica acts more as a carcinogen and less as a fibrosing agent.

Dissenting voices however still refuse to accept asbestos as a carcinogen, and in a recent article Braun and Truan⁴ report an epidemiological study of asbestos workers in Canada, showing that the incidence compares favorably with that in other workers. It should be noted, however, that the asbestos exposed to these particular miners was obtained from chrysolite, while that associated with lung cancer is usually derived from hornblende.

Iron: As mentioned in connection with asbestos, an association has been shown between siderosis and pulmonary carcinoma, statistics from Germany and England indicating that the incidence of carcinoma in hematite or iron ore workers is approximately two and one-half times as frequent as in the general population. However, in view of the frequency of the siderosis of welders one wonders why more cases of pulmonary carcinomata are not seen in this group of workers if the foregoing reports are true.

Beryllium: Of perhaps more immediate local interest is the metal beryllium, noted for its wide complexity of toxic effect in extremely minute dosage. Although it has been known for some time that osteogenic sarcoma could be produced by injection of beryllium it has not been possible until recently to demonstrate any carcinogenic effect by experimental exposure analogous with that of normal occupational use. However, recently Vorwald¹⁷ has shown that, under certain circumstances of prolonged inhalation, experimental animals could develop pulmonary carcinoma, and thus another hazard has been added to an already highly toxic material.

Asphalt, Coal Gas, Coke: In other fields, dust from asphalt paved roads has been incriminated as carcinogenic, and there was a suggestion 10 years or so ago from British investigators who examined the mortality statistics of pensioned gas-workers, that prolonged exposure to coal gas and

coke predisposed to respiratory cancer; further studies, however, in 1956 could not confirm this, although it was suggested at the time that a change in processing of the coal gas could have altered the incidence.

An interesting situation arises, too, among workers in coal and graphite. Investigators¹² in the Welsh coal fields have shown that there is a significantly lower incidence in lung cancer in coal miners than in the general population, and that where massive fibrosis and cancer are found in the same lungs it is relatively unusual to find the two conditions in apposition to each other. This suggests that there is an antagonism between the carcinogenic process and the tuberculous process of progressive massive fibrosis.

Atmospheric Pollution: Occupational exposure to potential carcinogens is, however, only one factor in the etiology of lung cancer, and there are other fields requiring, and receiving, urgent exploration, notably that of general atmospheric pollution, and in particular, the smog pollution of Los Angeles, London, Pittsburgh, and the like. How much of the hazard so discovered will eventually be laid at the door of industry is as yet a matter of speculation.

Conclusion

Cancer of the skin, bladder, and respiratory tract under some circumstances are of occupational origin. In many instances the specific etiologic agent is known. When such is the case complete prevention is possible and must be applied.

There are many areas of confusion concerning the occupational origin of certain cancers. Litigation in the courts of law has muddled rather than clarified the waters.

We are of the opinion that there are a number of cancers of occupational origin as yet unrecognized and with advancing technology there will be others. To recognize these, it is necessary to have excellent epidemiological data on the incidence of cancers of all types, in all organs, by age and sex *in the general population* and not just per 1,000 hospital admission. Against these data the critical industrial physician must plot the incidence in specific employee groups. These data will provide the clues necessary to initiate definitive research. Scientific proof of cause should be the only basis for the approval of occupational claims and can be the only effective basis for prevention. The hiding of evidence that can justify this proof is to be condemned and perhaps should be countered with strong legal measures.

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A Retrospective Study of Lung Cancer in Women

In a controlled, retrospective investigation of 158 women with pulmonary carcinomas, the largest and the only statistically significant effects were associated with smoking history. The scale of relative risks by intensity of cigarette use was greater for epidermoid and undifferentiated carcinomas than for adenocarcinomas. For epidermoid and undifferentiated carcinomas all the relative risks, with respect to smoking history and rate of cigarette use, differed significantly from unity at the 0.1 per cent level.

The findings agree substantially with those from three other studies of lung cancer in women. The combined results of several investigations suggest that the characteristic excess lung-cancer mortality among males almost disappears when nonsmokers are studied, since male nonsmokers have only slightly higher rates than female nonsmokers.—William Haenzel, Michael B. Shimkin, M. D., and Nathan Mantel, Biometry Branch, National Cancer Institute, Bethesda, Md.: *J. Nat. Cancer Inst.*, 21: 825-842, 1958.

Surgical Management of Nontoxic Nodular Goiter Presents a Controversial Problem

We are confronted with two schools of thought in the management of nontoxic nodular goiter. (1) Thyroidectomy in all cases. (2) Selection of cases. There is general agreement that large nodular goiters should be removed because of pressure symptoms and for cosmetic reasons. It is also generally agreed that the high incidence of papillary and follicular cancer in asymptomatic nodular goiter in children under the age of 15 years demands thyroidectomy. Routine thyroidectomy in nodular goiter in adults in an endemic goiter area, however, would lead to many unnecessary operations.

Cancer of the thyroid is a relatively rare disease. Only .5% of deaths from all cancer results from cancer of the thyroid. Furthermore, in this area about 2% of the male and 6% of the female population have asymptomatic nodular goiters. These observations favor selection of cases for operation based on the appearance of a solitary nodule, a rapid lobular increase in size of a goiter, hard irregular nodules, palpable cervical lymph nodes, and any other suspicious changes in the gland.

Having diagnosed thyroid cancer, there are again two schools of thought regarding the treatment of the papillary and follicular types. (1) Routine en bloc resection. (2) Total lobectomy and removal of the involved lymph nodes with many variations depending upon the extent of the lesion. Since the standard en bloc resection is inadequate as a radical procedure of removing all local and regional lymphatics, its advocates tend to admit that its use as a routine procedure is questionable. Most thyroid surgeons, however, use it when extensive regional metastases are present and in recurrent disease.—Carl W. Eberbach, M.D., Milwaukee: *Wisconsin M. J.*, 58:209, April, 1959.

Ventricular Arrhythmias Due To Glucose

It has been shown that an intravenous infusion of glucose will produce a drop in serum potassium. This is apparently due to a shift of potassium ions from extracellular fluid to intracellular fluid when glucose is assimilated by muscle cells under influence of insulin. With the drop in serum potassium cardiac arrhythmias have been reported. Patients who are receiving digitalis may show signs of toxicity when their serum potassium is reduced.—Fred H. Priebe, M. D., Indianapolis: *J. Indiana M. A.*, 52:205, February, 1959.

Rupture of the Diaphragm

WILLIAM BOGEDAIN, M. D., and JOHN CARPATHIOS, M. D.

AS A MATTER of clarification, in speaking of rupture of the diaphragm, we are talking about those cases in which the diaphragm is split from its anterior to the posterior position and usually through the central tendon. Articles have been in the literature in the recent years described as being diaphragmatic hernia of traumatic origin. In this article we are not speaking of those cases which are sliding diaphragmatic hernia of the esophageal hiatus or of the congenital type. Of the cases being presented in this article the diaphragm was actually ruptured for at least four or five inches in extent; the laceration was anterior to posterior in direction, and there was no peritoneal sac present around the abdominal contents.

The increasing speed of automobiles and the number of auto accidents has been blamed for the increasing incidence of this type of injury in recent years.¹ Two of our four patients were involved in severe automobile accidents. One case was due to an accident while in a hospital, and the fourth was due to a railroad accident.

In our city of Canton, Ohio, the actual accident rate does not show much change since 1955. In 1955 we had a total of 5,500 accidents in the city of which 14 were severe in nature and we had seven deaths that year. In the year 1957 we had a total of 5,350 accidents with 18 severe injuries and 13 deaths. For the first nine months of 1958 we had a total of 3,000 accidents with 15 being severe and six deaths. Of this total number of accidents, approximately 1,000 of the patients are taken to the hospital for observation. This figure has remained fairly constant for the last four years in this city.

Of the four cases which we are presenting we had one fatality. This patient also had serious head injuries which did not allow surgical intervention. The three other patients have been operated upon and are presently alive and well.

Three important features probably contribute to most of these ruptures of the diaphragm. The first and probably the most important factor is the sudden temporary increase of the intra-abdominal pressure, such as seen in steering wheel injuries. This increased pressure acts as a bursting force which tends to rupture the diaphragm, thus creating the defect. The negative pressure in the chest, acting as a suction, possibly also contributes to the presence of abdominal contents within the thoracic

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cavity. Since the liver protects the right leaf of the diaphragm it is unusual to find a rupture of the right leaf of the diaphragm.

Clinical Diagnosis

In a few cases early signs and symptoms may be insignificant. In the majority of cases, particularly those associated with severe trauma, rupture of the diaphragm should be suspected when there is atelectasis of the left lung. Most of the symptoms seen are associated with the cardiopulmonary system following automobile accidents. The circulatory system may be embarrassed by a shift of the heart or of the mediastinum to the right. Shock, cyanosis and tachycardia are present in most cases. Dyspnea is also a very common symptom, due to the reduction of the vital capacity, caused by the presence of abdominal viscera in the thoracic cavity and also the comminuted fracture of many ribs on the affected side. There is usually atelectasis of the left lower lobe when intra-abdominal contents are present within the chest.

The degree and intensity of all these symptoms may vary from very minimal distress to severe incapacitating situations. Pain in the upper abdomen and lower chest is usually present. This pain often radiates up to the left shoulder and along the left arm. This is due to the fact that the same cervical segments which form the phrenic nerve contribute to the formation of the lateral trunk of the brachial plexus. In several cases there were minimal or no symptoms which could be attributed to a possible diaphragmatic injury, immediately after the accident.

Vague symptoms suggesting peptic ulceration, coronary disease or gallbladder or even intestinal obstruction may manifest themselves after a con-

siderable period of time and obscure the real picture.² The history of an old crushing injury of the chest or upper abdominal contents—which in many instances is forgotten—with a delayed onset of gastrointestinal symptoms, may give a lead to the proper diagnosis.

Percussion may reveal the impairment of resonance within the chest. The complete absence of breath sounds, tympani or dullness over the left hemithorax must be explained. Sometimes peristaltic sounds over the left chest will certainly make the diagnosis. Intestinal obstruction in these cases is always a possibility. Several such cases have been reported.³ The x-ray findings in these cases are quite variable. Most often, the radiologist first notices either some atelectasis or gas content within the left chest. There may be elevation and distortion of the diaphragmatic contour. The mediastinum may have shifted to the right.

We have found that the presence of a Levin tube passed into the stomach is quite helpful on occasions. The large "U" turn taken by the tip of the Levin tube should be almost diagnostic of a diaphragmatic hernia, or ruptured esophagus. The performance of a barium swallow in the upper gastrointestinal series is certainly diagnostic in most cases when the stomach is within the chest. However, in some cases, it may be unwise to give the patient barium, especially in suspected concurrent esophageal rupture. In such cases the presence of the Levin tube within the chest cavity would certainly urge the surgeon to proceed with exploratory thoracotomy.

The only satisfactory treatment of these ruptures of the diaphragm is surgical reduction of the herniated viscera into the proper cavity and repair of the tear of the diaphragmatic leaf. We believe that this is best achieved through a left thoracotomy incision which can always be converted to a thoraco-abdominal approach when greater exposure is necessary. This incision is used only after a Levin tube has been placed into the stomach to decompress the gastric dilatation which is frequently present. Some of the advantages of the incision have been reviewed before.⁴ Phrenic crush can be easily accomplished through this incision and we believe that this is very important.

A number of cases have been reported in which the sutures of the diaphragmatic repair have torn out and recurrence of the hernia with strangulation has occurred with a lethal outcome. There are still a few surgeons who are doing these repairs through the abdominal cavity but they are becoming fewer and fewer as time goes on. The exposure of the contents of the lower left lobe of the lung and the heart certainly cannot be seen from

within the abdominal cavity. Should a piece of rib lacerate the lung or mediastinal contents, these injuries can be taken care of readily through the chest. Also, we know it is not unusual for the esophagus to be lacerated, contused or even perforated in such injuries. To repair such a defect from the abdominal side would certainly be a great task; in fact, it might be overlooked from the abdominal approach.

Case Reports

Case 1: This 56 year old white woman was admitted to Mercy Hospital through the Emergency Room in November, 1957. The patient had been in an automobile accident in which one of the passengers in the car was killed. On admission the patient was in obvious shock and had associated multiple rib fractures and multiple lacerations. Her condition improved but she remained short of breath. A portable x-ray of the chest taken on admission was suggestive of diaphragmatic hernia.

Two days following admission when the patient's condition had improved we saw the patient in consultation for the first time. A barium swallow performed the same day showed that the stomach was elevated into the left chest. Approximately four fifths of the stomach was above the left leaf of the diaphragm. There was also atelectasis of the lung field.

This patient was operated upon the day following the initial consultation. A standard posterior lateral thoracotomy incision was used. The left lower lobe was atelectatic and the abdominal contents were easily seen with the stomach and omentum protruding into the thoracic cavity. The central tendinous portion of the left leaf of the diaphragm was lacerated for a length of approximately 15 centimeters. This was in an AP direction. The spleen was also in the chest in this particular injury. The left lung could be seen to expand readily with assistance from the anesthetist and the atelec-

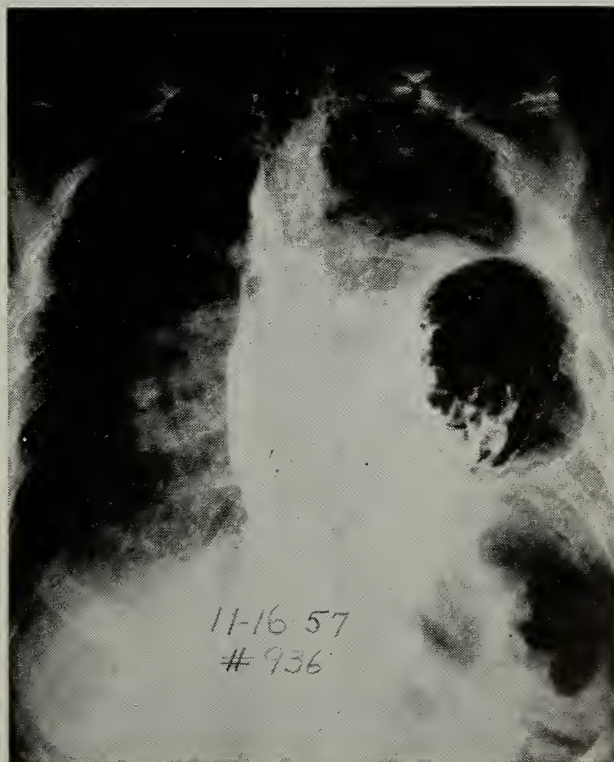


FIG. 1. Case No. 1. Barium meal shows stomach within the left chest.

tatic lower lobe was fully expanded when the chest cavity was closed. This patient was up walking the following day and subsequently made an uneventful recovery.

The barium meal in this particular instance shows the stomach well up into the chest with atelectasis of the left lobe (Fig. 1). The postoperative film shows the gas bubble in the stomach but this is now beneath the diaphragm. The left leaf of the diaphragm is temporarily paralyzed and has risen up into the left chest (Fig. 2).

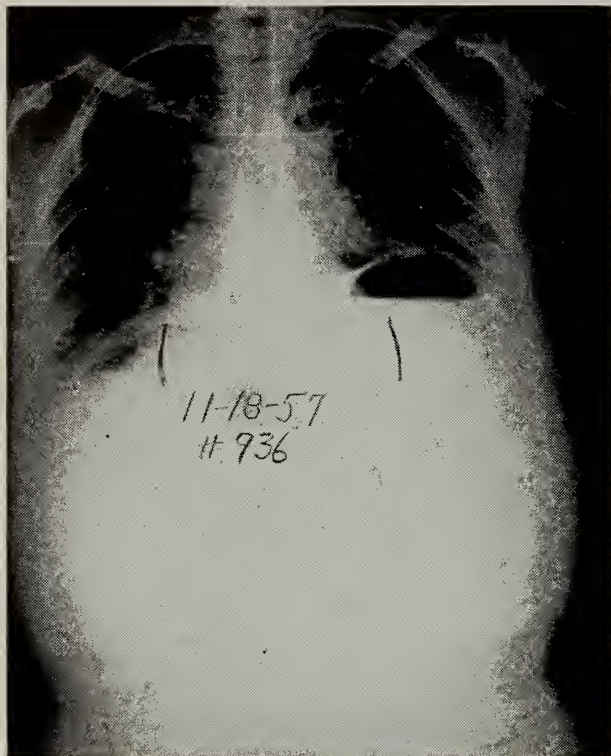


FIG. 2. Case No. 1. Postoperative, first day.

Case 2: This 41 year old white woman entered Mercy Hospital complaining of shortness of breath on exertion, and pain over the left lower chest. These symptoms had been present for almost a year but they had become more severe during the last month. This patient had previously worked in this hospital as a nurse's aide. Physical examination was negative except for diminished respiratory sounds over the left part of the lower chest. This patient almost forgot to tell us in her history that she remembers having had some pain in the upper part of the abdomen while at work one day. She was helping a patient back into bed and experienced a sudden pain while bending over.

We attempted to make a preoperative diagnosis in this particular case by taking roentgenograms of the large and small bowel, along with pneumoperitoneum and artificial pneumothorax. Figure 3 shows a mass in the lower left chest. X-ray studies were not diagnostic and for that reason we resorted to exploratory thoracotomy. At the time of operation we noted numerous adhesions between the left lower lobe and the parietal pleura covering the diaphragm. After the lung was mobilized we noticed a fatty tumor mass which later proved to be omentum, protruding up through a rent in the left leaf of the diaphragm. This laceration was approximately five inches in diameter. The mass was returned to the abdominal cavity and the diaphragmatic defect was closed in two layers, using interrupted No. 00 silk.

This was a typical case of a delayed diagnosis of a rupture of the left leaf of the diaphragm. Fortunately for the patient only a portion of greater omentum was herniated. This particular case was mistaken for a tumor of the left lower lobe.

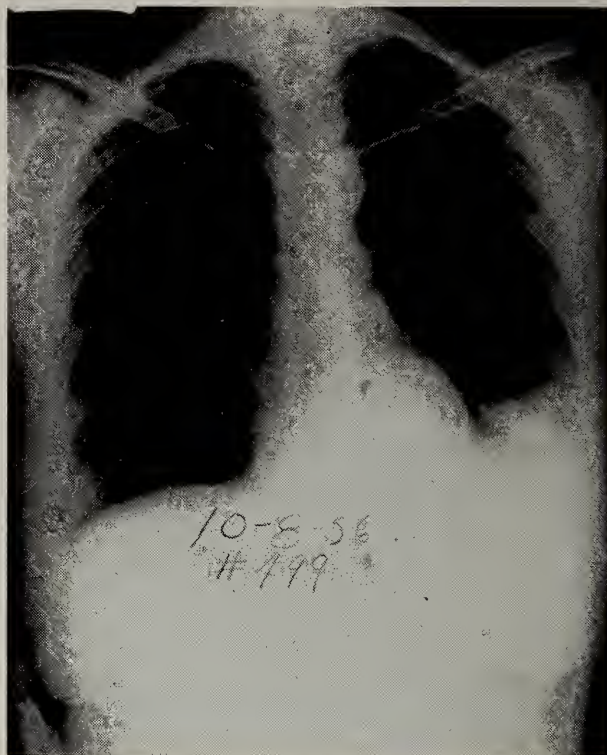


FIG. 3. Case No. 2. Preoperative diagnosis: Tumor left lower lobe. Postoperative diagnosis: Diaphragmatic hernia consisting of omental fat.

Case 3: A third patient (Fig. 4) was admitted to Mercy Hospital but did not live long enough to get to the surgical suite. This patient was squeezed between two freight trains in a nearby railroad yard. He demonstrated multiple rib injuries, subcutaneous emphysema, atelectasis of the lower lobe, in addition to his many other injuries of the head and abdominal contents. Although we did not have a chance to operate upon this patient because of his many other injuries, it does illustrate the type of compression which often causes this type of injury and also gives an insight as to the severity of the blow which is usually part of the history in these cases.

Case 4: A fourth patient was admitted to Mercy Hospital on the 20th of September, 1958. This individual was riding in the back seat of an automobile traveling 75 miles an hour. The automobile had turned over several times as it left the highway and the patient was brought to the emergency room of this hospital with many fractures and contusions of the chest. He was referred to our service several hours after admission and his condition improved with the administration of fluids intravenously, etc. A Levin tube had already been placed into the patient's stomach by the referring physician. This made the diagnosis quite easy in this particular case, since the tip of the Levin tube could be seen to take a "U" shaped turn and go up into the chest cavity (Fig. 5).

The patient was taken to the operating room within one hour after diagnosis since his condition clinically seemed to be slipping again. The entire stomach was



FIG. 4. Case No. 3. Multiple rib fractures. Gas bubbles high in left chest was stomach and abdominal content. Patient expired with associated head injuries before chest could be repaired.

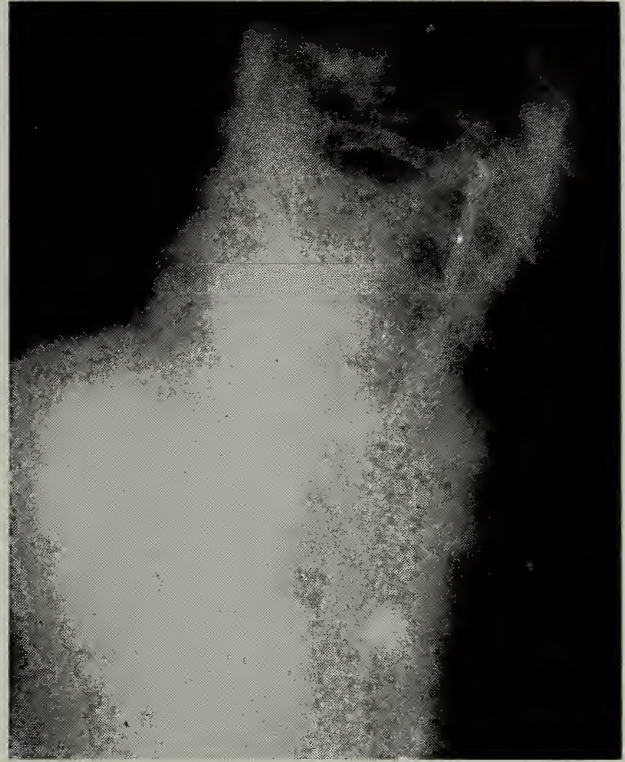


FIG. 5. Case No. 4. Tip of Levin tube, high in left chest. This can aid greatly in the diagnosis of rupture of the diaphragm or perforation of the esophagus. Barium studies were not necessary here.

found in the left chest. This was returned to the abdominal cavity. There was no evidence of perforation of a hollow viscus. It is interesting also to note that the distal third of the esophagus was severely lacerated through the longitudinal and circular muscle fibers. This injury was repaired at the time of surgery. The multiple sharp rib spicules were trimmed and alcohol injections of the intercostal nerves performed in the open chest to reduce the postoperative chest pain.

Although this patient is advanced in years, he has survived both the reduction of the hernia and a 75 mile an hour ride through the neighboring countryside. The day after the operation this patient was sitting in a chair, although he was still a bit incoherent from some cerebral concussion.

Conclusion

In conclusion, we have presented four cases of rupture of the left leaf of the diaphragm which were associated with trauma. Although the clinical picture is usually associated with severe trauma, one of our cases occurred when the individual was only moderately bending over a bed. This same case was mistaken for a tumor of the left lower lobe. In one of our cases the patient had co-existent injuries of the brain and abdominal contents which resulted in his death before surgery could be attempted. Another patient, in addition to the injury of the diaphragm also had a severe laceration of the circular and longitudinal muscles of the esophagus.

Co-existing atelectasis of the lung, in each case was improved at the time of surgery. This was accomplished by reduction of the hernia, bronchos-

copy while on the operating table, and positive pressure by the anesthetist under direct vision. Injuries of the spleen are easily handled through the thoracic incision. Sharp rib fragments, pulmonary, bronchial, and esophageal tears have been encountered. The latter injuries cannot be handled through the abdominal approach. This re-emphasizes the necessity for the thoraco-abdominal approach by someone who is familiar with chest surgery. Early diagnosis and prompt surgical repair can prevent disastrous complications.

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Prochlorperazine Preoperatively

A double-blind study has shown that prochlorperazine used before surgery in an effort to allay preoperative anxiety was only slightly better than a placebo. The preoperative use of prochlorperazine definitely reduces the postoperative incidence of nausea and vomiting. There were no side effects attributable directly to prochlorperazine in the double-blind study.—Eugene E. Eckstam, M. D., *Wisconsin M. J.*, 58:357, July, 1959.

The Use of the Artificial Kidney in Acute and Chronic Renal Failure

VICTOR VERTES, M.D.

THE fourth leading cause of death in hospitals today is renal failure. The mounting knowledge of fluid and electrolyte balance in recent years has made it possible to prevent death in many patients with acute renal failure and prolong the life of patients with chronic renal disease. The artificial kidney is a valuable adjunct in the treatment of these patients.

The causes of acute renal failure are multiple and lists of 50 or more have been computed.¹ Despite this long list, the most common cause, in our experience, seems to be transient reduction of renal blood flow due to periods of hypotension in a patient who already has some degree of renal disease. During surgery, and in the immediate postoperative period, changes in renal hemodynamics can rapidly occur and serious renal damage can be produced by only transient falls in the blood pressure. It is in these patients that one must be alerted to the possibility of renal failure and urine outputs must be closely watched. Other common causes include shock due to blood loss or myocardial infarction, mismatched blood transfusions, poisonings and acute glomerulonephritis. However, in most of these, the cause is not subtle as it is in the above mentioned situation and one is alerted to the possibility of renal failure.

Period of Oliguria

The period of oliguria in acute renal failure may vary from only a few hours to many weeks. The average length of time, in those patients whose oliguric phase extends over 24 hours, is 10 to 14 days. In those patients with short periods of oliguria (200-400 cc. per 24 hours), azotemia may be only slight and very rapidly the patient may go into the diuretic phase of acute renal failure and excrete voluminous amounts of urine. These patients may present serious problems in fluid and electrolyte balance, but are not usually candidates for extracorporeal hemodialysis.

When the oliguric phase lasts three or more days, dialysis should be seriously considered. With the advent of the twin coil disposable artificial kidney,³ many of the complications of dialysis have been reduced and, in the hands of a well-trained team, dialysis can proceed smoothly with only a minimum of complications.⁴ Because of this, the tendency in many centers is to treat acute

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renal failure earlier with dialysis rather than to wait for serious complications of oliguria to develop and then do the procedure on an emergency basis.⁵

Indications for Dialysis

Several guides to the seriousness of the oliguria can be used to decide when to treat the patient with dialysis. A rapidly rising nonprotein nitrogen or blood urea nitrogen in a patient who has been oliguric for over three days, is one indication. When the nonprotein nitrogen rises above 100 mg./100 ml. in a patient who had no previous azotemia, dialysis should be seriously considered as it is certain other metabolic derangements, such as acidosis and potassium retention are also proceeding. Elevations of serum potassium by 0.5 to 1.0 mEq./L. per day should be carefully watched and when the level reaches 7.5 mEq./L. or electrocardiographic changes of hyperkalemia occur, dialysis should be instituted. If the patient's clinical picture is rapidly deteriorating and he is plagued by progressive nausea, vomiting, increased neuromuscular irritability, somnolence or hiccoughs, dialysis should be performed. Any combination of the foregoing should call for dialysis.

Since most patients will "open up" in 10 to 14 days, we have dialyzed most patients with acute failure on days 5-9 of their oliguria. Occasionally, several dialyses are necessary before the patient goes into the diuretic phase and the same criteria are used for repeat dialyses. The chemical and clinical changes post-dialysis are usually remarkable and the patient can go through the entire course of oliguria with relatively little discomfort.

Chronic renal failure usually presents itself early as changes in the urinary sediment, fixed specific gravity, albuminuria, or azotemia. The patient may be asymptomatic during this period. As the disease process progresses, symptoms de-

velop and eventually he is admitted to the hospital in uremia. With proper dietary measures and fluid and electrolyte therapy, many metabolic derangements can be corrected and the uremia can be, at least temporarily, controlled. Eventually, all measures of therapy with diet, fluids and electrolytes fail and the patient goes into terminal uremia and dies. In selected instances, the artificial kidney can be very valuable as an adjunct in the management of these cases. Its use is purely palliative and can aid in decreasing the morbidity of these patients. No clear-cut criteria for its use can be presented as in acute renal failure and considerable clinical judgment is necessary in the decision.

Dialysis in Chronic Renal Disease

Three types of responses are possible with dialysis.

In the first of these, within a week or two, the patient is as bad clinically as he was before dialysis—a failure.

The second type of response is that the patient has a good remission with a return to normal life for a period of one to six months.

The third type of response is a remission lasting more than six months.

Most patients with chronic renal disease fall into the first two categories. Patients whose remission has lasted more than two to three months, can then be re-treated and any of the three possibilities can again occur.

Patients with severe vascular disease characterized by severe hypertension, hemorrhages or exudates in their fundi, or a past history of cerebrovascular accidents or congestive heart failure, usually respond very poorly. Often, patients with polycystic kidney, chronic pyelonephritis and occasionally those with chronic glomerulonephritis, have a good response to dialysis. Those patients having an acute exacerbation of the chronic renal disease due to an intercurrent illness, surgery, or other acute contributing factors, usually have a good response. It is quite true that the majority of these cases in the latter categories would possibly respond to conservative management, but the decision for prolonged hospitalization and prolonged intravenous therapy versus six hours of dialysis with minimal hospitalization and intravenous therapy must be made.

Conclusion

(1) The artificial kidney is a valuable adjunct in the treatment of acute and chronic renal failure.

(2) In acute renal failure, a rapidly rising non-protein nitrogen, evidence of potassium intoxication or rapid clinical deterioration are indications for dialysis and the morbidity and perhaps the mortality of the oliguric phase can be diminished.

(3) In chronic renal disease, the indications for dialysis are not as clear-cut. Patients with severe vascular disease respond poorly. In patients with polycystic kidneys, chronic pyelonephritis, chronic glomerulonephritis and acute exacerbation of chronic renal disease, the artificial kidney can aid considerably in the management of the decision for dialysis or conservative management must be made in each case.

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Corticotropin and Steroids in the Diagnosis and Management of "Obstructive" Jaundice

Corticotropin and several steroids were shown to influence the jaundice present in five patients with intrahepatic obstruction (hepatitis) and in seven patients with extrahepatic obstruction (carcinoma); furthermore, the drugs, as used in this study, were of value in the differential diagnosis between intra- and extrahepatic obstruction as the cause of the jaundice.

The test used consisted of daily administration for four to eight days of 40 to 60 mg. of oral prednisone, 60 units of injectable corticotropin, 200 or 300 mg. of oral cortisone, or 12 mg. of triamcinolone. Serum bilirubin and serum alkaline phosphatase concentrations were measured before and after the tests. In four of the five patients with intrahepatic obstructive jaundice caused by hepatitis, a rapid and profound improvement in jaundice was seen and the reductions in serum bilirubin levels, 8 to 12 per cent daily, exceeded any that occurred in the patients with extrahepatic obstruction due to carcinoma. The reduction in serum bilirubin levels in these latter patients was 1 to 7 per cent daily.

Although less striking in degree, the reductions in serum alkaline phosphatase concentrations were usually similar to those of the serum bilirubin in either type of patient. The practical importance of the test, however, is the continued administration of these drugs, when a patient has shown some definite response on the initial test, because sustained improvement justifies a confident diagnosis of hepatitis.—(*Abstract*): Summerskill, W. H. J., and Jones, F. Avery, London, England: *Brit. M. J.*, 11:1499-1502, December 20, 1958.

Recovery from Anuria After Suffocation in Nitrogen—Treatment with the Artificial Kidney¹

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DAVID C. HUMPHREY, M.D.

RENAL tubular necrosis is believed to occur as a consequence of diminished renal cortical blood flow and, often, of a reduced systemic arterial blood pressure. The case reported is of significance because renal tubular necrosis followed suffocation in nitrogen, in the absence of hypotension.

Case History

A 42 year old white workman, while cleaning the interior of a large industrial tank, collapsed when nitrogen was inadvertently used for ventilation. He was found unconscious. On examination, 20 minutes later, he was still in a coma, and the systolic arterial blood pressure was 120 mm. Hg. During the next 12 hours he was delirious and agitated. Acute renal failure occurred, along with anorexia, nausea, emesis, azotemia and oliguria, without hematuria. He was lucid after the initial period of coma, but his sensorium became progressively more depressed thereafter. The daily output of urine totaled about 80 ml.

The family history and the past medical history were noncontributory.

On the seventh day, he was admitted to the Cleveland Clinic Hospital. He was stuporous; the tendon reflexes were symmetrically hyperactive, but the superficial reflexes were normal. The cranial nerves and optic fundi appeared normal. Findings from examination of the skin, heart, lungs, and abdomen were normal; the blood pressure was 140 mm. Hg systolic and 70 mm. Hg diastolic.

A small amount of urine obtained by catheterization had a specific gravity of 1.012. Many erythrocytes were in the sediment, and the reaction for albumin was 2 plus. The results of blood studies were as follows: the total leukocyte count was 7,250 per cu. mm.; the hemoglobin was 11.4 Gm. per 100 ml.; the hematocrit value was 37 ml. per 100 ml.; the differential leukocyte count was 75 per cent segmented and 9 per cent band neutrophils, 14 per cent lymphocytes, and 2 per cent monocytes. The blood urea was 162 mg. per 100 ml., and the creatinine was 8.8 mg. per 100 ml. The serum electrolyte concentrations are summarized in Table 1.

Hemodialysis with the disposable twin-coil kidney*^{1,2} was performed on the day of examination. There was notable improvement of the mental state, though delirium and agitation did recur. Figure 1 shows the graphed results of dialysis. On the third day after dialysis, he was normally oriented, though he had an amnesia concerning the events of the day of the accident and several days thereafter. He could walk with assistance. Gradually there was depression of the sensorium, which was thought to be due to the recurrence of the uremia.

A second dialysis was performed on the seventh day of admission. Oliguria persisted until the twenty-fourth

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day after the accident, when the urinary output reached 1,000 ml. per 24 hours for the first time. Nevertheless, because of azotemia and hyperkalemia (serum potassium of 7.2 mEq./L.) the third dialysis was performed. The patient improved, especially his mental condition. On the fourth day after the third dialysis, the urinary output increased to 5,000 ml. per 24 hours.

Antihypertensive drugs† were given when needed to reduce the blood pressure to within normal range. The patient gradually improved, regained his appetite and overcame his mental depression. On the day of discharge, the thirty-first day after the accident, the azotemia had disappeared entirely.

On examination one year after the accident, renal function had apparently returned to normal, as indicated by the Addis test, the urea clearance test, the excretory urogram, and the serum electrolyte determinations. However, neurologic, psychiatric, and psychometric evaluations indicated slight, but definite residual cerebral changes.

Discussion

The acute renal failure in this case was primarily due to anoxia. According to Smith³ most investigators report that in unanesthetized animals and in man, anoxic hypoxia causes transiently increased diuresis together with generally increased urinary chloride excretion. On the contrary, in anesthetized animals, anoxic hypoxia usually leads to oliguria or to anuria. Since hypoxia may affect the tubular cells, the renal circulation, the secretion of adrenalin and antidiuretic hormone and, possibly, the secretion of the adrenal cortex, the changes in urinary flow as well as changes in composition of the urine are uninterpretable without further information.

†Serpasil® (reserpine Ciba) from Ciba Pharmaceutical Products, Inc.; Ansolsen® (pentolinium tartrate) from Wyeth Laboratories.

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*Commercially available from Travenol Laboratories, Inc.

TABLE 1. Data on Electrolyte Status in an Anuric Patient Who Was Treated With Hemodialysis.

Days after onset of anuria	Na mEq./L.	K mEq./L.	Cl mEq./L.	HCO ₃ mEq./L.	Urea mg. %	Creatinine mg. %	Uric acid mg. %
7—Before dialysis	135	4.70	85	17.2	168	8.8	
9—After dialysis	125	4.30	94	19.2	78	4.8	
11	132.5	4.95	89	24.0	108	6.9	
13	130	4.90	92	24.0	165	8.6	
13—Before dialysis	123	6.30	84	12.9	159	11.4	14.5
15—After dialysis	138	5.60	96	21.8	81	6.8	7.9
17	139	6.0	94	22.7	156	9.0	
17—Before dialysis	142.5	7.2	84	20.6	195	8.3	13.0
19—After dialysis	142.5	4.8	96	26.9	89	4.4	
23	135	5.0	90	25.2	139		
28	148	4.5	95	24.0	96		
	138.5	4.6	105	25.7	46		5.7

In a recent study, Földi *et al.*⁴ obtained consistent changes in six men after they breathed a nitrogen gas mixture having only 10 per cent oxygen. On the average, urinary output decreased by 45.5 per cent, urinary sodium by 55.4 per cent, glomerular filtration by 48.6 per cent, while para-aminohippuric acid clearance decreased to 39.2 per cent of the prehypoxic period.

Whether or not in our patient renal tubular necrosis was due to anoxia without reduction of renal blood flow cannot be stated, even although

hypotension never was observed. The cerebral changes in the patient are considered to be sequelae of anoxia.

After three dialyses this patient recovered from severe acute renal failure.

Since disposable easy-to-run artificial kidneys are available,⁵ we believe that a patient in acute renal failure should be given the benefit of hemodialysis before his clinical condition deteriorates to an irreversible state. With frequent dialysis it often is possible to maintain a patient in a state of

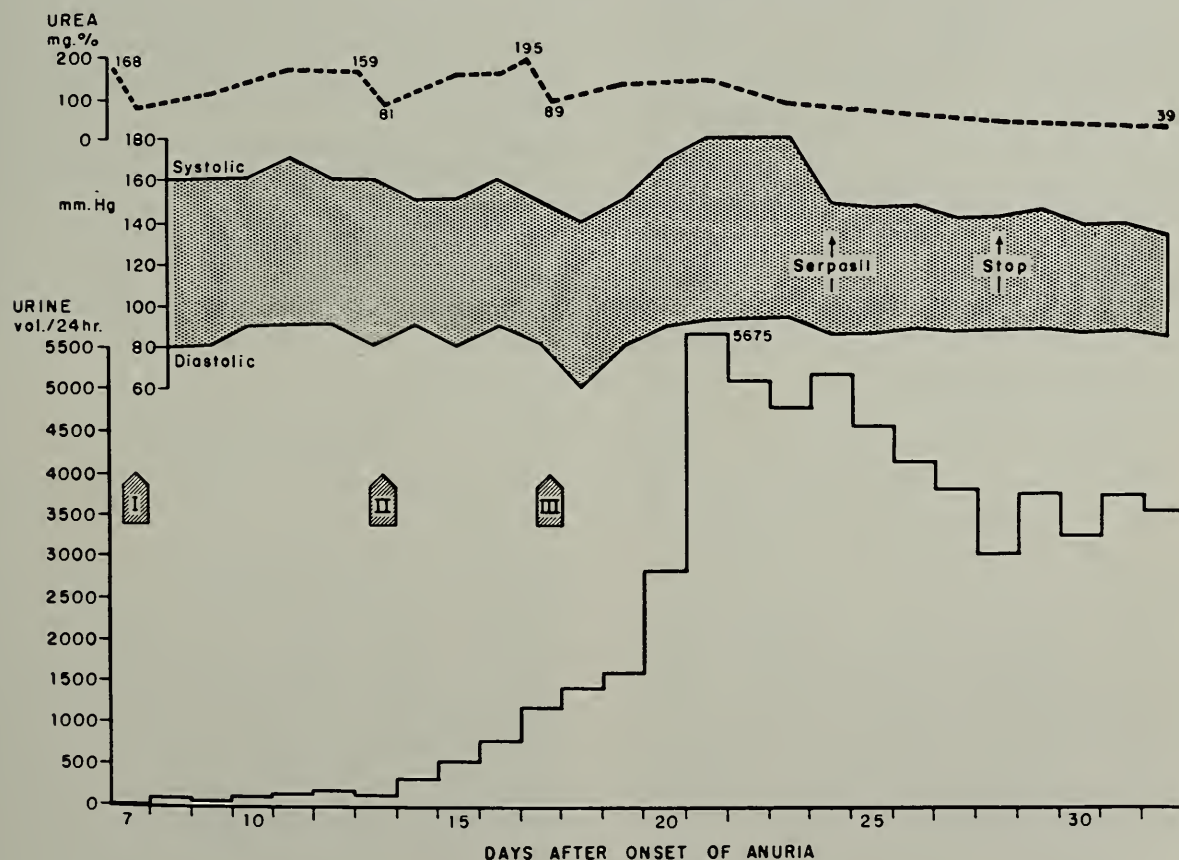
RECOVERY FROM ANURIA AFTER SUFFOCATION IN NITROGEN
TREATED WITH THE ARTIFICIAL KIDNEY

FIG. 1. A 42 year old man became oliguric (urinary output of 80 ml. per day) after suffocation in a tank filled with nitrogen. I, II, and III indicate dialyses with the twin-coil artificial kidney.

reasonable well-being so that the onset of diuresis may be awaited with confidence.

Summary

A 42 year old man was suffocated in nitrogen gas and became comatose. Though a fall in blood pressure was not noticed, he became severely oliguric (urinary output was 80 ml. per day). He was treated three times with the disposable twin-coil artificial kidney. On the eighteenth day the urinary output reached 1500 ml. and he recovered.

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A New Chemical Solvent For Urinary Calculi

A new chemical solvent which may rid patients of some kidney stones in a short time has been announced by Dr. William P. Mulvaney, clinical instructor in surgery on the University of Cincinnati College of Medicine urologic staff, who conducted the basic clinical research on the solvent, called Renacidin. Tests in the laboratory and on selected patients had shown Renacidin to be effective in treatment of calcium and magnesium phosphate and carbonate stones, which comprise about 40 per cent of all kidney and bladder stones.

Renacidin tends to dissolve stones of mixed oxalate phosphate composition more slowly, however, some of these are made soft and porous, ready for crushing by instrumentation, following treatment with Renacidin.

The solvent is composed primarily of the lactones and acid salts from food products. It is applied by "irrigation," utilizing a continuous slow drip upon the stones. In as few as 15 hours, according to Dr. Mulvaney, the susceptible stone can be softened or reduced to the point where it can be eliminated from the body or removed by instruments.

Dr. Mulvaney worked for six months with a chemist testing Renacidin on stones already removed from patients and upon animals. Clinical testing on selected patients was begun about a year and a half ago. So far no irritating side effects have occurred from the use of Renacidin.

Dr. Mulvaney presented his results in a paper read at the annual meeting of the American Urological Association in Atlantic City, April 20-23, 1959.

Nature and Treatment Of Septic Shock

The authors re-emphasize the frequency with which septic shock occurs in severe surgical infections and report the survival of 16 of 41 recent patients with septic shock who were treated by the method devised by them. Their plan of treatment includes: (1) immediate intravenous infusion of fluids, particularly plasma or blood, to correct any deficiency of the circulating blood volume without overloading the circulation, (2) massive intravenous doses of antibiotics, (3) arterenol given by intravenous drip at a rate that restores blood pressure to 80 mm. Hg. or above, (4) use of an indwelling catheter to measure the hourly urinary output, which is maintained between 25 and 75 cc/hour by the proper administration of arterenol and fluid, (5) continuous administration of oxygen by nasal catheter or tent, (6) elevation of the foot of the bed by 12 to 18 inches, (7) withholding cortisone or hydrocortisone unless fluids and arterenol cannot restore or maintain blood pressure, and (8) timed surgical intervention when indicated and feasible. It is important that treatment be started before shock becomes terminal or irreversible.

Hydrocortisone was used in three patients and appeared to be life-saving. The authors' early fears of permitting general dissemination of bacterial infection by cortisone therapy appear to be incorrect. Dr. George S. Henegar, in discussing this paper, told of his experience in severe peritonitis. He used intravenous hydrocortisone hemisuccinate as an immediate treatment and followed it with corticoids given by the intramuscular and oral routes. Hydrocortisone not only elevated blood pressure but also seemed to block the toxic effect on the peripheral cells.—(*Abstract*): Altemeier, William A., and Cole, William R., Cincinnati: *Arch. Surg.*, 77:498-507, October, 1958.

Occlusive Disease of the Carotid Arteries

Occlusions of the carotid arteries may be responsible for over 20 per cent of all acute cerebral vascular lesions. The clinical pictures produced by carotid occlusions are quite variable, and can mimic those of brain tumors, middle cerebral artery occlusions, and other conditions. There are few clinically diagnostic features for carotid occlusions. Definitive diagnosis requires arteriographic study. There is some evidence that early institution of anticoagulant or surgical reconstructive therapy in certain patients with carotid occlusions is indicated.—Allen Silverstein, M. D., New York: *Circulation*, 20:4-16, July, 1959.

Nosebleeds — Radical Surgical Treatment

Presentation of a Case

E. E. MIHALYKA, M. D., and THOMAS KRIEZAK, M. D.

ONE of the most exasperating entities that any doctor has to deal with is the very frequent and common "nosebleed." Through the years many methods have been devised to attempt to help the patient suffering from painful and sometimes fatal nosebleeds. According to authorities,^{1,2,3,4,5} nosebleeds can be treated by symptomatic medication, by cauterization with silver nitrate, by nasal packing, or by whole blood transfusion.

Following is the procedure we recommend for management of intractable nosebleed. First, the patient must be subjected to thorough diagnostic evaluation including hematologic study, complete physical examination, and hypertensive study. Prior to the nose bleed, the patient's blood pressure may be elevated, but afterwards and by the time the patient sees a physician the blood pressure is often almost within normal limits. One must not disregard hypertension as a causative factor in frequent nosebleeds.

When an individual presents himself with a "nosebleed," generally speaking, treatment can be conservative. In many instances, simply applying continued pressure for approximately 10 to 15 minutes to both external nares usually stops bleeding. If the initial conservative therapy does not seem to control the bleeding, bilateral anterior nasal packings may be inserted. Posterior packs with bilateral anterior nasal packs may also be necessary. If, however, the patient continues to bleed through his packs, even through several pack changes over as many days, plus the additional help of whole blood transfusions, the physician must then resort to radical surgery. The following is a presentation of such a case:

Case Report

The patient is a 63 year old white man who entered the University Hospitals, Cleveland, for the first time on August 13, 1957, because of "nosebleed." The past medical history revealed no serious illnesses or operation. The patient has been a known hypertensive for approximately five years for which he has been treated for the past year with phenobarbital 0/016 Gm. three times a day. He has had one episode of epistaxis five months prior to this admission, and was treated at another hospital with anterior and posterior nasal packs as well as whole blood transfusion. Anterior packs were inserted during the day before admission.

Physical examination revealed a well developed, fairly well nourished white male who had bilateral anterior

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nasal packs in place. Blood pressure was 160/110, pulse rate 92/min., and respiratory rate 18/min. Temperature was 36.4°C. The eye grounds revealed a grade 2 retinopathy with slight increase in the tortuosity of the vascular vessels and there was arteriovascular nicking. No hemorrhage was noted. There was slight oozing from the bilateral anterior packs, but no active bleeding was observed. There was no bleeding into the nasopharyngeal area at this time. The rest of the physical examination was within normal limits.

Laboratory Data: The patient's hemoglobin was 13.2 grams (87 per cent); hematocrit 41 per cent; white blood cell count 9,700/cu. mm. with normal differential. Urinalysis revealed 1 plus albuminuria with occasional hyaline casts and 1 to 2 white blood cells per high power field. The Lee-White clotting time was seven and one-half minutes and 10½ minutes (second tube). Bleeding time was two minutes and 14 seconds. Prothrombin was 83 per cent. The chest x-ray was normal.

No further bleeding was noted in the morning and the packs were removed revealing punctate areas of bleeding bilaterally on the septal wall, a little less on the right side. Similar abnormalities were noted on the lateral wall of the left inferior turbinate. These bleeding points were cauterized with silver nitrate and bleeding ceased. That evening bleeding was again noted on the right anterior septal wall. This stopped with compression. Again, several small areas of the right septum were cauterized with silver nitrate. The patient was then treated with Synkavite,[®] ascorbic acid, phenobarbital, penicillin and streptomycin.

There was no further bleeding noted until the fourth hospital day when his blood pressure, which had been running around 170/100, rose suddenly to 220/120 and profuse generalized epistaxis occurred. No anterior bleeding points could be found so a posterior nasal pack and bilateral anterior nasal packs were inserted. Nevertheless the patient continued to ooze slightly through the packs. Concomitantly the backflow of blood through the nasolacrimal ducts caused an irritative conjunctivitis. Once again, no bleeding was noted for the next 72 hours although the hematocrit dropped from 40 to 33 per cent and his hemoglobin dropped down to 11.4 grams.

On the sixth hospital day the patient again started to bleed actively and 500 cc. of whole blood was given. The packs were removed and bleeding points on the

septum were again cauterized. The patient was unable to take fluids because of the packs and was maintained on intravenous fluids throughout the course. For the next 48 hours the patient oozed blood slowly but without noticeable active bleeding.

On August 22, 1957, (the ninth hospital day) another posterior pack was inserted with a bilateral anterior packing with vaseline under general anesthesia. It was noted again that blood continuously oozed from the anterior portions of the packing. The hematocrit rose to 39 per cent after transfusion, but then suddenly fell to 22 per cent and the hemoglobin fell to 8.2 grams. The white blood cell count rose to 13,800/cu.mm.

On the eleventh hospital day, August 24th, active bleeding occurred from the left side of his nose through the anterior and posterior nasal packs, and it was decided that surgery should be resorted to. Accordingly, he was taken to surgery where whole blood transfusion was started again. The procedure planned was ligation of the left anterior and posterior ethmoid artery.

Operation: The nasal and facial areas were properly prepared. The eyebrows were retained. A "Hockey Stick type" incision was made extending from the left supraorbital ridge down to the nasal suture line. The dissection was carried down and the periosteal elevator was utilized to reflect the periosteum lateralwards.

The Luango retractor was gently inserted until the left anterior ethmoid artery was isolated, ligated, and divided. With further dissection and lateral reflection of the periosteum of the eyeball itself and continual gradual deeper insertion of the Luango retractor, the posterior ethmoid artery came into view in the form of a "tenting" along the lateral wall of the nasal side of the eyeball approximately $1\frac{3}{4}$ inches deep. A pair of silver brain clips were placed across this vessel, one proximal and one distal. The vessel was not divided. The patient received three units of whole blood throughout this procedure.

The incision was closed and a Penrose rubber drain inserted and Aureomycin® ophthalmic ointment instilled into both eyes. An eye pack and dry dressings were applied to the left eye. Bilateral anterior and a posterior nasal packing was re-instituted following surgery. The patient withstood the procedure well and left the operating room in good condition.

During the next 36 to 48 hours he seemed to be doing well with no further bleeding. The hematocrit rose to 30.5 per cent after transfusion. Bleeding time was repeated and was two minutes, while the clotting time was eight minutes and platelet count was normal. Prothrombin time was 100 per cent. Electrolyte balance was maintained.

The anterior nasal pack was removed slowly over a period of two days. Forty-eight hours postoperatively, all packs were out and there was no bleeding. Twenty-four hours later, on August 27, at about 7:00 a.m. (the fourteenth hospital day) third postoperative day, the blood pressure suddenly rose to 140/90 and the patient had another epistaxis of approximately 150 cc. from the right side of his nasal cavity this time. Several small bleeding points were noted and cauterized with silver nitrate and Adrenalin®. Oxycel® packs were inserted into the right anterior and posterior portions. Profuse epistaxis continued, however, on this side and it was decided that the right anterior and posterior ethmoid artery should be ligated.

Once again on this day, August 27, 1957, at 9:00 a.m. under general anesthesia a posterior pack was inserted and the right anterior nasal pack was re-inserted. No bleeding was noted from the left side throughout all of this. Once the right side packing was inserted, the vital signs remained fairly stable and the patient was again given blood transfusion. It was decided that the patient should be observed. Towards the evening of August 27 the patient again passed large amounts of

swallowed blood per rectum and it was decided because of persistent bleeding on August 28th, that the right anterior and posterior ethmoid artery ligation should be carried out.

Second Operation: On August 28, 1957, again under general anesthesia, the patient's right facial and nasal areas were properly prepared. An incision was made through the right supra-orbital ridge down toward the nasal suture line and dissected. The Luango retractor was inserted and the right anterior ethmoid artery was isolated, ligated, and divided. The periosteum of the right eyeball was elevated and reflected lateralwards and again the Luango retractor was inserted deeper into the orbit until the posterior ethmoid artery was revealed at a depth of 2 inches. The brain clips were utilized again and placed on the proximal and distal parts of the posterior ethmoid artery. A rubber drain was inserted and the incision was approximated and closed with No. 0000 black silk. One per cent Aureomycin ophthalmic ointment was instilled into both eyes and a right eye dressing and patch was applied. Again the right side posterior and anterior packing was inserted. The patient withstood this procedure well and he left the operating room in good condition.

The blood pressure continued to hover around 170/100 all through the operative procedure and through the first postoperative day. On the second postoperative day, the blood pressure gradually dropped to 150/90 and there was a small amount of oozing through the pack posterior and anterior, but no active bleeding noted. The nasopharynx was clean and dry. On August 30, 1957, the second postoperative day (for the second surgical procedure), the packs were removed with no active bleeding noted at this time. During the next two weeks, the patient was followed very carefully and no further bleeding occurred. The hemoglobin returned to 11.6 grams, the hematocrit rose to 38 per cent and the rest of the laboratory values were within normal limits. The stools became guaiac negative and the patient was finally discharged on his thirty-second hospital day. He had received a total of 12 pints of whole blood and on the discharge day his blood pressure had been maintained at approximately 150/90.

Follow-Up: Now, one year later, the patient has been followed by his internist and monthly by us. His blood pressure has been maintained at 150/90, and there has been no further bleeding.

Conclusion

A 63 year old white male, who is a hypertensive with resistant nosebleed not responding to usual conservative therapy, required radical surgery consisting of bilateral anterior and posterior ethmoid artery ligation. The bleeding was severe enough to require transfusion of 12 pints of whole blood in order to maintain stable blood pressure. The patient is being followed monthly. This may be a very radical approach to hypertension, but it is worthy of further investigation.

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Chemical Burns

A Case Report on Preventable Blindness

WILLIAM H. HAVENER, M.D.

A BLIND EYE is a serious loss to both patient and community. Awareness of the preventable nature of a significant portion of this blindness should help in reducing the incidence of such tragedies. The representative cases to be presented here are selected to emphasize relatively common causes of blindness which can in many instances be averted by proper, timely care.

Case Report

While applying waterproofing compound to a concrete wall, this 23 year old college student fell off his ladder, and splashed the solution into both eyes. *No attempt was made to wash the eyes.* He was taken to a physician's office a considerable distance away. This physician immediately irrigated this strongly alkaline material from the eyes, but both corneas were already a dense white color, which obscured all view of the iris.

Despite vigorous medical therapy (as subsequently outlined) one and a half months elapsed before epithelial healing was complete. Permanent corneal scarring of both eyes reduced his vision to light perception. Now more than a year after the accident, two corneal transplants have been done on each eye. Vision in the right eye is a very poor 20/200; left eye, light perception. Further attempts will be made at transplantation, but his chances for additional improvement of vision are slight.

Discussion

Immediate, prolonged irrigation with plain water will prevent more blindness from chemical burns than will all other medical care combined. There is no time to search for specific antidotes such as vinegar or baking soda, nor are they appreciably more effective. Complete removal of a caustic solution requires about 20 minutes of gentle irrigation. This should be done at the site of the accident, as first aid. Further irrigation with water or normal saline should be done at the doctor's office, since the first aid care almost never will be completely adequate. Under topical Ophthalmine® anesthesia, a careful search should be made for particulate matter, which may require mechanical removal with a cotton swab. Fluorescein staining will help to identify the clumps of mucus which adhere to irritant chemicals.

Infection of the burned surfaces should be prevented by the use of topical antibiotics (for example, Neosporin® drops every two hours while awake until the epithelium has healed). Systemic antibiotics are unnecessary. Corneal scarring and neovascularization can be minimized by topical steroid therapy, which should be used in all cases of severe corneal burns. Minor epithelial abrasions do not benefit from steroids, which should not be used for minor injuries because they reduce resistance to infection. *Atropine* and

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homatropine are the medications most often neglected in cases of this sort. Whenever extensive corneal injury or inflammation occurs, iritis will invariably be present. Iritis is easily recognized through smallness of the pupil and photophobia. Dilatation of the pupil will relieve symptoms and prevent synechiae.

Use of an ointment vehicle is important in preventing adhesions between apposing raw conjunctival surfaces. In severe chemical burns it is necessary to pull the lids away from the globe every few hours in order to break these adhesions, which form with surprising rapidity during the first several days. Eye pads will often make the patient more comfortable, especially if firmly applied. Healing is not more rapid with or without an eye pad, use of which is optional and depends upon the patient's comfort. The pain from an ocular burn is very severe, and usually prevents the patient from working. This pain is best relieved by sedatives, ice packs, and codeine. Repeated use of topical anesthesia is very undesirable because it inhibits epithelial healing.

Blindness can be prevented by emphasizing in all first aid programs the importance of prompt and thorough irrigation of eyes burned by caustic chemicals.

Chlorpromazine—Four Years Later

A four year assessment of chlorpromazine used on once highly regressed patients, with lengthy hospitalizations, then discharged, permits the conclusion that this is an indispensable mode of treatment.—W. Tuteur, M.D., et al.:—*Illinois M. J.*, 116:9, July, 1959.



MATERNAL HEALTH IN OHIO

Case No. 164

This 31 year old colored woman, gravida II, Para I, two weeks past term, was dead on arrival at hospital, undelivered. Past medical history was unavailable, except that the patient had been hospitalized, due to mental illness, three years prior to her death. For the past three years she had complained of headache, dyspnea and palpitation of the heart. There were no complications during first pregnancy or delivery six years ago.

During this second pregnancy she consulted her physician when seven months pregnant. Her blood pressure was 180/100 and weight 210 pounds, compared to her average weight of 190 pounds. The urine was negative. A month later the blood pressure was 240/100 and urine showed 3 plus albumin. Bed rest was advised, a low salt diet and Veriloid® prescribed. She was last seen two weeks later (two weeks prior to death) and blood pressure was the same, weight 230 pounds, and still the patient was not hospitalized. Two weeks later the husband was awakened by the patient complaining of shortness of breath. She tore off her clothes and rushed out on the porch, where she was found by the police called by her husband. She was in severe respiratory distress and died on the way to the hospital. An autopsy was performed.

Pathological Diagnosis: Cerebral anoxia; pulmonary edema; myocardial failure due to hypertensive heart disease; pregnancy at term, undelivered.

Comment

The Committee voted this case a preventable death on a basis of inadequate prenatal care. It was felt that although the patient registered late, had she been hospitalized following the first office visit, consultation obtained, and a program of intensive therapy instituted and continued, her course could have been improved, or stabilized at least.

This case and the following case report demonstrate the need for continued education on the importance of good prenatal care.

One of the functions of this Committee, in publishing reports, is to stimulate obstetricians to be on the alert always for complications. From the records this patient might have been hospitalized, intensive therapy begun and the pregnancy terminated at 33 weeks even if anticipated ultimate improvement were slow or negligible.

Case No. 183

This patient was a 42 year old colored primigravida, who died undelivered at 31 weeks gestation. The only information concerning her past history was the mention that she had had cystitis in 1948 and hypertension.

TOPIC THIS MONTH:

Maternal Deaths* Involving Toxemia

With last menstrual period November 28, she consulted her doctor at 18 weeks gestation and made a total of four prenatal calls, at three week intervals. At the first office visit no unusual findings on physical examination were reported other than blood pressure of 168/90. Three weeks later the blood pressure was 190/120, trace of albumin in the urine and slight ankle edema. These findings were the same three weeks later when in her 24th week of gestation. Six weeks later her blood pressure was 258/130, urinary albumin 3 plus, and edema of lower extremities 3 plus. She was sent to an internist. There is no record of the opinion or therapy suggested by the consultant, June 28.

Five days after seeing the consultant this patient entered the hospital when in her 30th week of gestation. She complained of epigastric pain. On admission, her temperature was 99°, pulse rate, 92/min., respiratory rate 20/min., blood pressure 150/90. There was 3 plus edema of lower extremities and some edema of face. There was 4 plus albuminuria; the urine was positive for bile and the urine was loaded with red blood cells and white blood cells. Hemoglobin, hematocrit, and white blood cell count near normal limits.

The patient was treated with bed rest, low sodium diet, Ansolysin® 40 mg. three times a day, digitoxin .2 mg. daily, Donnatal® 1 four times a day, and Carbital® on occasion. Epigastric pain increased in severity, urinary output decreased, there was rather marked epistaxis, and on the second hospital day the blood pressure rose to 212/140 and the patient was stuporous. Nonprotein nitrogen was 71 mg./100 ml, urea nitrogen 44 mg./100 ml., spinal fluid was under markedly increased pressure and grossly bloody. Later in the day she had a convulsive seizure, stupor, Cheyne-Stokes breathing and blood pressure which had been 230/150 began to drop until it was unobtainable. Finally, there was a profuse epistaxis following which the patient died at 4:30 p. m. on the second hospital day. An autopsy was performed.

Pathological Diagnosis: Toxemia of pregnancy; petechial hemorrhages of the cortex of the cerebrum and

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by official representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

thalamus; necrosis and fatty degeneration of the liver; petechial hemorrhage of the renal cortex bilaterally; ulceration of the stomach; congestion of all organs; pregnancy seven and one-half months, undelivered.

Comment

The Committee voted this a preventable maternal death. Why the delay in the hospitalization of this patient? Members felt that hypertension and cardiovascular renal disease was the cause of death rather than acute toxemia. The laboratory and postmortem findings support this view. A combination of hypertensive vascular disease and acute toxemia (preeclampsia) or a superimposed preeclampsia upon a known hypertensive condition may occur, but it is not common. While profuse epistaxis might have been due to the marked hypertension, severe liver damage with a decrease in the formation of fibrinogen and prothrombin undoubtedly played an important part in the bleeding in this case. Laboratory studies are not available to support this contention.

Case No. 185

This 30 year old white woman, gravida II, Para I, died undelivered when seven months pregnant. She had no prenatal care and apparently no one knew that she was pregnant until the coroner discovered the seven months gestation at autopsy.

Information concerning her past medical history was painfully meager. When 20 years of age, in 1946, she went to a physician for a premarital blood test, which was reported nonreactive. She consulted this physician again on September 9, 1948, when two months pregnant. This physician later learned that she was delivered in another town in February, 1949. In 1954 she was dismissed from a state hospital and prescriptions were given to her for the control of epileptic seizures. It is known that she had these prescriptions for phenobarbital and Dilantin® refilled on June 11 and December 31, 1954, and on the latter date her weight was 246 pounds. She was last seen alive by a doctor when she had a refill of her prescription for Dilantin on February 11, 1956.

At 10 a. m. on July 20 her mother heard her moaning and on going into her room found her lying face down on the floor, bleeding from the nose and mouth and biting her tongue. Her mother stated the patient had not had an epileptic seizure for six months. A local physician pronounced her dead at 11:40 a. m. July 20, and called the coroner, who performed an *autopsy*.

Pathological Diagnosis: Acute pulmonary edema; brain stem edema; cardiac dilatation; pregnancy, seven months uterine, toxemia of pregnancy. (The coroner's records do not mention epilepsy, obesity, pathology found in the liver or kidneys, and no mention was made of a head injury.)

Comment

In this case the Committee had few pertinent facts and lacked adequate information as to blood pressure, whether or not there was albuminuria, edema, headaches, etc. We know that she was a very obese epileptic who was probably of low mentality; she had no prenatal care. The difference between epileptic and eclamptic convulsions was discussed in de Sauvage's *Nosology*, published

in 1763, and since that time much has been written on epilepsy in pregnancy.

Based upon the facts available, the Committee could not agree upon a cause of death; (a) status epilepticus vs. (b) head injury sustained during epileptic seizure; or (c) toxemia of pregnancy. However, members did vote this a preventable maternal death (P₂), patient or family responsibility.

Comment of Consultant

The following comment of a consultant who is a specialist in obstetrics and gynecology, was given at the request of the Committee.

Toxemia of pregnancy is still one of the leading causes of maternal death. It is a syndrome of the third trimester and early puerperium, characterized by the elevation of blood pressure, edema and proteinuria; in severe cases it may lead to convulsions, coma and death. If convulsions occur the disease is called eclampsia; in the absence of convulsions, preeclampsia. Since premonitory signs such as sudden excessive weight gain, clinical edema, hypertension and proteinuria are almost always apparent to the physician before the patient becomes aware of any symptoms, it is extremely important that routine prenatal examination of all obstetrical patients be done at frequent, regular intervals.

All three of these reported cases demonstrate only too sadly the need of continued education on the importance of adequate prenatal care. The objectives in the treatment of toxemia of pregnancy are two-fold: to prevent eclampsia in the mother, and to allow the pregnancy to progress to a stage of certain viability for the infant. Specific therapeutic measures for preeclampsia fall into three categories (1) elimination of salt and edema fluid, (2) sedation and (3) termination of the pregnancy.

The milder forms of this disease can be treated at home if close contact with patient can be maintained. Progressive increase in severity of the patient's condition must then be considered an urgent indication for admission to the hospital. The majority of patients with preeclampsia undergo prompt clinical improvement in response to a regime of bedrest, salt depletion and sedative drugs. If after a few days of this conservative therapy it becomes apparent that the anticipated improvement is not occurring, a decision must be made whether or not to terminate the pregnancy after balancing the risks. On the one hand are maternal risk and hazard to the fetus if the pregnancy is allowed to continue. On the other hand is the risk of premature birth if the pregnancy is interrupted. When termination of pregnancy is

elected, it should be performed in the most conservative manner, compatible with the urgency of emptying the uterus.

Case No. 164: In light of our present knowledge in treatment of toxemia of pregnancy, the patient was at fault in not reporting for prenatal care before the seventh month. The attending physician was also in error in not seeing this patient frequently when he noted that her blood pressure was elevated, and in delaying admission to the hospital when it was seen that the patient's toxemia was becoming progressively worse.

Case No. 162: The physicians should have seen this patient more often and should have admitted this patient earlier when it was seen that a severe preeclampsia was apparent.

Case No. 185: Pertinent facts are too meager for comment. While the cardinal clinical feature of eclampsia is the convulsion, it must not be assumed that every pregnancy or puerperal patient with convulsions is an eclamptic. A convulsion is a rather nonspecific manifestation of a variety of pathological conditions, including epilepsy, brain tumor, cerebral vascular lesion, meningitis, diabetes, anemia, drug poisoning, anoxia, tetany and hysteria.

The immediate objective in the treatment of eclampsia is the control of convulsions. No attempt should be made at delivery nor should surgical procedure be carried out until the eclampsia has been brought under control. The convulsions often initiate labor or result in fetal death in utero. When the patient has been free of convulsions for 24 to 48 hours and spontaneous labor does not ensue, the condition should be treated as a severe preeclampsia. If the fetus is alive but not viable it may be justifiable to treat the patient medically in an effort to carry the pregnancy to 33 to 34 weeks. Recurrence of the toxemia demands immediate termination of the pregnancy. If the fetus is dead, however, artificial termination of the pregnancy is usually unnecessary since fetal death in utero is almost always followed by clinical improvement in the mother. The patient can therefore be treated expectantly and the spontaneous onset of labor awaited.

Treatment of Meniere's Disease With Ultrasonic Waves

Animal experimentation and clinical experience have demonstrated that a selective destruction of the vestibular labyrinth can be achieved with ultrasonic waves. The attacks of paroxysmal vertigo cease and hearing is preserved in patients with Meniere's disease.—Richard P. Ariagno, M.D.: *Illinois M. J.*, 116:22, July, 1959.

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEPFEL, M. D.
Columbus, Ohio, Chairman

Following is the summary of a case which was discussed before the Franklin County Pelvic Cancer Delay Committee on July 15, 1959, at its regular monthly meeting held at the University Health Center.

Case No. 72. The patient is a 62 year old white woman who developed vaginal bleeding one month prior to admission. The family physician did a pelvic examination and referred the patient in for dilatation and curettage.

This patient has been seen by her family physician periodically (at least three times a year) for the last six years relative to complaints of back ache, arthritis and constipation. During this period of time a pelvic examination was not carried out nor was any Papanicolaou smear taken.

Pelvic examination on admission reveals fungating lesion of cervix extending into right fornix. The patient is scheduled for central radiation with Cobalt and external x-ray therapy.

Comments

DR. EZELL: This is a lesion which was diagnosed even by gross inspection. It is true that microscopic diagnosis must be made, but one can be quite certain of the diagnosis when the lesion reaches this size. So in all probability, this lesion could have been seen a year or more before patient presented with bleeding.

DR. POMEROY: This patient has a Clinical Stage II squamous cell carcinoma of the cervix and has a fifty-fifty chance of survival at this time. Her prognosis, of course, would have been greatly improved with an earlier diagnosis.

DR. HOLZAEPFEL: *Physician delay:* four years; *Patient delay:* zero. This disease can be eradicated only if found in the early stages. It can be cured. We now have the facilities available through the Papanicolaou smear and biopsy technique to make early diagnosis. Without the initial steps of routine pelvic examination, all other means of diagnosis are invalidated.

Management of the Complicated Duodenal Ulcer

The complications of hemorrhage, obstruction, and perforation occur in patients who have the most severe type of duodenal ulcer. These are the patients that require the best ulcer treatment.

Complete, continuous, supervised treatment is of utmost importance. The patient must be taught to anticipate and to treat a recurrence of ulcer activity immediately and thoroughly. It is the only method now available to treat ulcer recurrences and to keep complications at a minimum.—Joseph Shaiken, M.D., Milwaukee: *Wisconsin M. J.*, 58:215, April, 1959.

A Clinicopathological Conference

Edited Under the Auspices of the Ohio Society of Pathologists

CHARLES BLUMSTEIN, M. D., *President*

Presentation of Case

THIS 23 year old Negro man was apparently in good health until two months prior to his first admission to the University Hospital, Columbus, Ohio, when he developed a painless jaundice accompanied by dark urine and light stools, but without itching, abdominal pain or anorexia. There was no history of blood transfusions, intravenous injections, or contact with relatives or friends with jaundice. He was employed in the auto wrecking business and had daily exposure to carbon tetrachloride for perhaps six months, two years prior to admission. The patient also used gasoline and naphtha to clean grease from his hands. One week prior to admission the patient became weak and remained so. Systemic review was negative except for frequent epistaxis.

On physical examination the patient appeared well developed and well nourished. His sclerae were icteric. The remainder of the physical examination was noncontributory except for a grade 2 systolic murmur over all valve areas. Laboratory data at admission showed: red blood cells 2.44 mil./cu. mm., hemoglobin 8.1 Gm., white blood cells 5,700/cu. mm. with normal differential count; sickle cell preparation negative; platelets 711,680/cu. mm. Total protein was 8.5 Gm., albumin 3.07, globulin 5.43 Gm.; van den Bergh direct 6.35 mg., indirect 9.5 mg.; thymol turbidity 100; cholesterol 75 mg., esters 45.7 per cent; blood urea nitrogen 11 mg.; alkaline phosphatase 14.82 units. The urine contained bile but was otherwise normal. A bone marrow biopsy showed normoblastic hyperplasia but no abnormal cells or L. E. cells. The patient left the hospital without permission.

The patient, at age 29, returned six years later for 14 days. The chief complaint was swelling of his legs and abdomen. He had been intermittently jaundiced for short periods, and in the last six months ankle edema and shortness of breath developed. The patient showed greenish-brown rings around the limbus of the cornea. There was dullness to percussion in the base of the thorax bilaterally, with decreased breath sounds. The extremities showed 1 plus pitting edema. A mass in the left upper quadrant of the

Presented by

- William F. Ashe, M.D., Columbus, and
 - Emmerich von Haam, M.D., Columbus.
- Edited by Dr. von Haam.

abdomen was interpreted as an enlarged spleen.

The laboratory data showed a hematocrit of 35 per cent and a hemoglobin of 11.2 Gm.; white blood count 3,050/cu. mm. with normal differential count. The prothrombin time was 19.8 per cent; total protein 7.8 Gm., albumin 1.9, globulin 5.9; van den Bergh direct 1.9 mg., indirect 3.1 mg.; cholesterol 104 mg., esters 57 per cent; Congo red retention 16 per cent; thymol turbidity over 100. Examination of the urine sediment revealed it loaded with red blood cells. The antistreptolysin "O" titer was 333 units. The serum transaminase was 88 units. Copper studies of his blood showed an average of .96 mcg. per cc., and of the urine an average of .36 mcg.

During his hospital course the patient was treated symptomatically and received Mercuhydrin® followed by weight loss. He was discharged on a low fat, high carbohydrate and high protein diet, to be followed in the clinic.

He was readmitted four months later complaining of abdominal swelling, shaking chills and an upper respiratory infection. Jaundice was again present, and there was a fluid wave in the abdomen with shifting dullness and fullness in the flank. The liver was felt 4 fingerbreadths below the costal margin; the spleen was nontender and was 4 fingerbreadths below the costal margin. Laboratory studies were similar to prior ones. The patient was treated with a 500 mg. sodium diet with calcium chloride supplement, mercurial diuretics and Diuril®, and lost 19 pounds.

Two months later he was readmitted because of recurring ascites with progressive enlargement of his abdomen, swelling of the legs, and dyspnea. There was no detectable icterus of the sclerae, and reaction to the van den Bergh test was 1.9 mg./100 ml. direct and 2.8 mg. indirect. During his hospital stay the patient was afebrile throughout,

had repeated thoracenteses and paracenteses, and one bout of mental lethargy. His prothrombin time remained low despite vitamin K therapy. He lost 23 pounds and at the time of discharge had demonstrable ascites, mild peripheral edema and minimal pleural effusion.

Fifth Admission

Eighteen days later the patient was admitted for the last time. His main complaint was recurrent ascites and pleural effusion. On the day of admission he had abrupt onset of sharp pain in the right chest aggravated by deep breathing and coughing, with shortness of breath. There was a suggestion of scleral icterus. The chest had diminished breath sounds; there were increased fremitus and dullness over the lower half of the right chest. The abdomen was distended and showed a fluid wave. The liver was 2 finger-breadths down and was slightly tender. There was edema of the presacral area, the scrotum, and the legs. There was tremor of the outstretched hands but no gross flap.

Laboratory Data: The hematocrit was 29 per cent; hemoglobin 9.6 Gm.; white blood count 13,800/cu. mm., with 89 per cent polymorphonuclear neutrophil leukocytes. The direct van den Bergh was 2.6 mg./100 ml., indirect 4 mg.; blood urea nitrogen 54 mg.; serum sodium 138 mEq/L serum potassium 2.7 mEq., blood chlorides 109 mEq.; CO₂ combining power 44 vol. per cent; total protein 6.9 mg., albumin 1.7, globulin 5.2. Repeated blood urea nitrogen showed values of 66, 90, 71, and 114 mg. The thoracentesis fluid had specific gravity of 1.007 and did not contain acid-fast bacilli or malignant cells. Stool and urine cultures showed no definite pathogens.

Hospital Course: On the day of admission a right thoracentesis obtained 1500 cc. of straw-colored fluid. The patient was treated with a high protein, high carbohydrate, high caloric diet and received Mercuhydrin. Thoracentesis was repeated twice and a total of 4000 cc. of fluid was obtained. Paracentesis was productive of 3800 cc. of fluid. The patient gained 10 pounds in three days and his course was progressively downhill. On the day prior to death he became confused and disoriented, had petechiae on his abdominal wall and arms, and flap of his outstretched hands. On the morning of death the patient was confused, and he died quietly at 10:30 a. m. of his nineteenth hospital day.

Clinical Discussion

DR. ASHE: This is really a very excellent case, one which challenges the ingenuity and logic of

the clinician in attempting to arrive at a diagnosis. It is the history of a young colored man who over a period of six and a half years developed a disorder of the liver and a disorder of protein metabolism resulting in a collection of fluid in various parts of his body and an anemia from which he ultimately died.

If one were to look at the first sentence of this protocol, one would have to consider first and foremost a pancreatic or ampulla of Vater tumor. However, in the course of his diagnostic evaluation it became quite apparent that he had some sort of chronic liver disease. The evidence for this chronicity lies in the greatly disturbed protein metabolism with a reversed albumin/globulin ratio, persistent jaundice, and the altered alkaline phosphatase. I think that an individual who had a simple infectious hepatitis, so mild as to produce only a little bit of weakness and no anorexia or abdominal distress, could not in so short a period have had so much disturbance of his liver function as to alter these proteins so markedly. Furthermore, one expects to see in chronic liver disease a maturation arrest at the erythroblast-normoblast level and not at the megaloblast level as seen in pernicious anemia. Therefore his bone marrow picture was reasonably compatible with some sort of chronic liver disease.

It states in this protocol that for a period of some six months a couple of years prior to admission he had daily exposure to carbon tetrachloride. We know that carbon tetrachloride is a hepatotoxic agent. An individual who has excessive exposure to carbon tetrachloride first shows central nervous system symptoms, then evidences of acute disease of the liver and kidney. If he survives the acute period of intoxication his liver may return to normal, but if the exposure is extended over a considerable period of time he may develop cirrhosis. But the clinical evidences of cirrhosis were not present at his first admission to the hospital.

Six years later he returned to the hospital telling us that he had had intermittent bouts of jaundice and now had developed ankle edema and shortness of breath. Physical examination at that time revealed greenish-brown rings around the limbus of the cornea, which may have been Kayser-Fleischer rings, which are part of the syndrome of Wilson's disease. He had anemia, and again evidence of a very marked disturbance in protein metabolism.

Someone must have felt that he had amyloid disease, because they did a Congo red test, which was within the limits of normal. The Congo red

test can be very misleading in either primary or secondary amyloidosis unless one understands that one has to have enough amyloid in liver and spleen to retain a significant amount of Congo red. Primary amyloidosis of the gastrointestinal tract or the heart would not have enough amyloid to absorb a lot of Congo red, and therefore this test is not diagnostic unless the liver is full of amyloid. Because of the greenish rings, which were interpreted as Kayser-Fleischer rings, studies of his copper metabolism were done. They showed a low blood copper content and a low urinary secretion, which speak at least in part against the presence of Wilson's disease.

Fluid Retention

Four months later he was admitted again with jaundice and abdominal swelling. He was put on sodium restriction and they were able to get water out of him remarkably well. About two months later he complained again about progressive enlargement of the abdomen and again mild jaundice was present, but this time not nearly so severe as on previous admissions. He did have the additional symptom of mental lethargy. They tried to improve his coagulation mechanism by vitamin K, but did not succeed. The pleural effusion, the edema and the ascites diminished on therapy and he was again sent home.

Eighteen days later he was admitted for the last time, with recurrence of fluid in the abdomen and the development of severe shortness of breath, which was believed to be due to pleural effusion. He had an occasional attack of a sharp onset of pain in his chest. He continued to be jaundiced. His soft heart murmur is not incompatible with the degree of anemia which he was found to have. There was tremor of the outstretched hands but no particular flapping. The laboratory data showed a considerable degree of anemia, but this time with leukocytosis. His van den Bergh was elevated but not nearly as high as the first time. Now he showed some evidence of renal failure with an elevated blood urea nitrogen. His electrolytes and his CO_2 were below normal, and his blood proteins were again markedly abnormal with as low an albumin as you are likely to see.

His blood urea nitrogen rose and fluctuated, which is of some importance, because if this man had a significant or almost total hepatic insufficiency his urea should not have risen as it did. The thoracentesis showed a low specific gravity fluid. The bacteriological examination was negative. Stool and urine cultures were likewise negative. He gained weight very rapidly in spite of

what they did for him and went downhill. He developed petechiae all over his body and became confused and disoriented. He died on the nineteenth hospital day of this last admission, which was six and one-half years after the onset of his disease as we know it.

Differential Diagnosis

In considering a differential diagnosis one could go in a great many directions, some of which I shall omit. If this individual had sub-clinical injury to his liver and to his kidneys from exposure to carbon tetrachloride and he developed infectious hepatitis, could he then have developed cirrhosis of the liver of an atypical variety and died from that situation? We do not find evidence in this protocol that the ascites and the edema were due to portal obstruction. We don't find spider angiomas, we don't find venous anastomoses over the abdomen, and we do not see conspicuous evidence of esophageal varices on the x-rays or of hemorrhoids in the rectum. There is sufficient reason for the collection of fluid in the presence of his low albumin level, and one does not have to call on portal cirrhosis for its explanation. Furthermore, if this be true, then he already had portal cirrhosis on his first admission, because there was already evidence of chronicity of his liver ailment.

Why, then, did he not have any of the classical symptoms of Laennec's cirrhosis at that time, or at least develop the classical symptoms of this disease over the next six years? There are rare conditions of liver, kidney, lung and brain which are grouped together under the name of polycystic disease, or Lindau-von Hippel disease. However, in these patients jaundice or death from hepatic failure is virtually unknown, and the cases follow the usual pattern of polycystic kidneys.

Amyloidosis?

Somebody thought he might have had amyloid disease. Atypical amyloid disease may present itself anywhere, but usually we see it in the mouth, tongue, gastrointestinal tract, heart, and perhaps liver and spleen, without the necessity of any chronic infection. When this is so, the diagnosis is best made by biopsy. His stomach, intestinal tract, and his esophagus did not show clinical evidence of this condition. The Congo red test neither proved nor disproved it. The presence of abnormal numbers of plasma cells in the bone marrow at his second admission suggested it to a degree, because there is some evidence that this curious saccharide-peptide combination called amyloid has its origin in plasma

cells. But I don't think this is sufficient to make that diagnosis with any degree of certainty.

Hemochromatosis?

Then there are disturbances of the pigment metabolism, such as hemochromatosis, which affect the liver and spleen and may result in disturbances of the protein metabolism. This is a fibrotic disease resulting from the precipitation of hemosiderin in the cells of the liver, thyroid, pituitary, gonads and pancreas with ultimate destruction and cirrhosis and fibrosis, and later in the heart and elsewhere. He did not have the big, hard liver of hemochromatosis, nor did he have diabetes or gonadal atrophy. There is no evidence that he may have had anything remotely resembling Addisonian crisis, although at one time his sodium was low. His blood pressure was always normal, and I am inclined to think that hemochromatosis can be ruled out.

Collagen Disease?

Certainly a number of people thought very carefully about a collagen disease of the lupus variety, but they did not find lupus cells. While absence of lupus cells does not disprove the diagnosis, the chances that he would live as long as he did with lupus are exceedingly remote. Furthermore, evidence of renal disease should have been quite marked by the time of his second hospital admission, and evidence of progressive cardiac disease should have been present.

Tumor, Specific Infection?

Is it possible that this patient had some disease of the liver on top of which he developed a tumor? We know that hepatomas do develop in cirrhosis of the liver, but I was unable to find any clinical evidence of a primary tumor of the liver or pancreas. We also see liver disorders of infectious character—perhaps cysts, or a staphylococcus abscess. Sometimes they rupture into the chest, but the fluid in our case seems to be the same sort of transudate which was in the abdomen. It certainly was not the pus of an amebic abscess, and it certainly was not the grossly infected pus which one would expect if one were dealing with the rupture of an abscess from the liver into the lung.

Wilson's Disease

Finally, we come to this interesting disease—Wilson's disease, or hepato-lenticular degeneration. It has been known for a long time as a rare disease and has been studied rather extensively recently. It is a disease which appears usually very early in life; it may occur in children; it frequently occurs in the 20 to 30 age rubric. Re-

cently it was found to be a familial, recessive and sex-linked disease based upon a disturbance of copper metabolism.

Patients with Wilson's disease have a very high tissue copper and a very high excretion of copper in the urine, so we cannot make the diagnosis from the copper studies reported in this case. I must go back and try to decide whether the laboratory was right and therefore this could not be Wilson's disease, or whether the clinicians were right in the description of a Kayser-Fleischer ring, which almost certainly has to be Wilson's disease. I am inclined to feel that probably the clinicians were right. So I think, Dr. von Haam, that this is an interesting exercise which merits the discussion of the new information on Wilson's disease as a clinically recognizable entity. We can recognize it by detecting specific proteins in the blood and by determining accurately the copper metabolism. We can find it familiarly. It is preventable in the future because it has now been proved to be definitely gene-linked, congenital in origin, and I am inclined to think that probably this man did have hepato-lenticular degeneration.

Clinical Diagnosis

1. Wilson's disease (hepato-lenticular degeneration).

Pathological Diagnosis

1. Postnecrotic cirrhosis of the liver.
2. Cholemic nephrosis.

Pathological Discussion

DR. VON HAAM: The body was that of an adult, jaundiced Negro man showing severe edema of both legs and the scrotum. The abdominal cavity contained 2200 cc. of a dark yellow fluid. The right pleural cavity contained 1500 cc. of fluid, while the left pleural cavity contained 200 to 300 cc. The heart appeared grossly normal. The right lung was collapsed; the left lung was intensely congested and weighed 700 grams. The spleen weighed 600 grams and was firm and reddish-brown.

The liver weighed 1000 grams. The entire left lobe appeared atrophic. The right lobe showed numerous brownish-green nodules measuring up to 3 cm. in diameter. The cut surface showed similar nodularity with broad bands of gray fibrous tissue between the nodules. No stones were present in the gallbladder or bile ducts. No varicose veins could be recognized grossly in the esophagus. The stomach contained 500 to 700 cc. of partially digested blood; the small intestine was filled with similar material, while the large intestine was unremarkable. The

kidneys appeared large, brownish-green and edematous. The brain weighed 1240 grams and was grossly normal.

Microscopic Examination: Microscopic examination of the lungs showed extensive pulmonary hemorrhages with edema and early bronchopneumonia. Sections of the esophagus showed moderate varicose veins and ulcerations covered with *Monilia*. Sections through the liver showed most of the normal liver tissue destroyed and replaced by large nodules of regenerated liver tissue. The left liver lobe showed no regeneration of the liver cells but was completely replaced by proliferated bile ducts. The few remaining islands of normal liver tissue showed well demonstrable central veins and no degenerative changes.

The patient's bile capillaries were distended and filled with bile, but the larger bile ducts appeared empty. The spleen showed fibrosis of the pulp as the result of chronic portal hypertension with areas of calcium-iron encrustation and more recent hemorrhages. Sections of the kidney showed tubular degeneration with bile casts. Sections of the brain showed no significant pathologic changes.

From this autopsy we felt that the patient some time ago suffered a severe parenchymatous injury of his liver, at which time practically nine-tenths of the liver cells were destroyed. Rapid regeneration of the right liver lobe saved him from death from acute liver necrosis at that time. This regeneration was responsible for the occurrence of portal hypertension and possibly also for his jaundice due to intrahepatic bile duct obstruction. Special copper stains of the liver and the eyes showed no excessive amounts of tissue copper.

I believe this patient died from the condition which is sometimes seen in India, where the livers of young children are destroyed by hepatotoxic agents and where the livers have this tremendous power of regeneration, so that the patients do not die from acute liver failure but from post-necrotic cirrhosis with portal hypertension and chronic liver failure. I can well imagine that the carbon tetrachloride exposure some years ago could have been the cause of his liver trouble, but I cannot prove it.

DR. ASHE: I found it difficult to arrive at this conclusion clinically because the portion of his medical history suggesting such massive liver collapse is missing. He could not have been a well man walking around in this situation, and at his first admission he already showed a chronic liver condition. I certainly have not found such a case in my experience with carbon tetrachloride poisoning.

Familial Patterns in Hypertension And Coronary Heart Disease

Studies have been made of the prevalence of hypertension and of coronary heart disease in two successive generations of subjects.

The greatest proportion of affected persons was always found among the offspring of two affected parents and the smallest proportion among the offspring of two unaffected parents. This finding is consistent with the hypothesis that hypertension and coronary heart disease are hereditary disorders, at least in part.

While the most striking correlations were seen when the prevalence of the same disorder was studied in two successive generations, similar but less striking correlations were found when hypertension was investigated in one generation and coronary disease in the other.

The female relatives of hypertensive women were found to have more than twice as much hypertension as their male relatives, while the male relatives of hypertensive men had almost twice as much hypertension as their female relatives.—Caroline Bedell Thomas, M. D., Baltimore, Maryland: *Circulation*, 20:25-29, July, 1959.

Esophagitis Is Diagnosed Too Infrequently

Esophagitis is probably the most frequent abnormality of the esophagus, yet the diagnosis is made too infrequently.

The modern descriptions of the anatomy and physiology of the esophagogastric sphincter mechanism have partly clarified the pathogenesis of the larger group of esophagitis which excludes that caused by ingested corrosives and poisons.

Failure of this sphincter mechanism as an effective barrier results in the reflux of corrosive gastric juice. The resulting esophagitis which is observed most often with hiatal hernia, also occurs following intubation, severe vomiting, and plastic operations on the esophagogastric junction. A coexisting duodenal ulcer increases the severity of the esophagitis and is a threatening factor in stricture formation.

It is clinically significant that esophagitis coexists in over half the cases of pyrosis and this association is worthy of vigilance.

Surgeons should be alerted to the serious complication of ulcerative esophagitis, and stricture that not infrequently follows postoperative intubation for duodenal ulcer while plastic surgery on the esophagogastric segment rarely escapes a similar fate.—Michael W. Shutkin, M.D., Milwaukee: *Wisconsin M. J.*, 58:219, April, 1959.

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1. Innerfield, I.: Clinical report cited with permission

2. Clinical report cited with permission



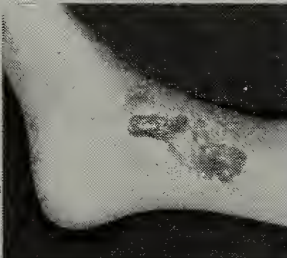
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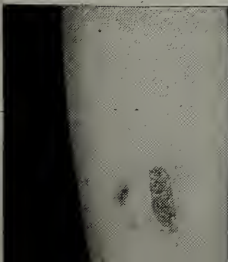
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PRESIDENT'S PAGE

WHEN the 103rd session of the Ohio Legislature convened in January a remarkable situation, indeed, existed. A high percentage of the elected representatives were new.

A different party was in the majority and an atmosphere conducive to major social reform appeared to prevail. Moreover, some of those in prominent position in the legislature were definitely hostile to the medical profession. Many bills having an important bearing on the health and welfare of the people of Ohio, and on the medical profession, were placed in the mill. The session is now completed, however, and it may be said with reasonable assurance that medical progress was achieved during this session of the Legislature and that, for the most part, those bills which would have influenced unfairly the high standards of medical care which prevail in Ohio were defeated.

The Council considered in detail all of the bills of significance to the medical profession and established a policy in reference to these bills. For the most part the majority of the legislators gave conscientious consideration to the help extended by the medical profession in many measures. The list is too long to enumerate in this message, but the attitude of the State Legislature in two particular instances, polio and cancer, is an example of the cooperative effort between the men who make the laws and the men who care for the sick.

For information on the outcome of the various medical-health bills, read thoroughly the legislative review appearing elsewhere in this issue of *The Journal*.

Indeed the medical profession can feel that it has advanced with this recent session, but this did not come about by accident. Medicine has been represented before the legislature by diligent and competent men. George (Scottie) Saville and Hart Page under the direction of the executive secretary, Charles Nelson, were the eyes and ears of the profession during the last seven months. With skill they convinced the legislators that the policies established by the medical profession were constructive and not selfish. They achieved a firm understanding and won the confidence of the legislators. They deserved this confidence. The people we elect to legislative office cannot possibly be experts on every subject which confronts them. Specialized fields usually find that earnest and sincere cooperation with the legislators wins its rewards. Constant opposition is always suspected. Ours certainly is an extremely specialized field. The representatives of our Association were opposed only when they could not show evidence of a position of confidence. They were able to convince the majority that our purpose was that of constructive help, and this help was welcome.

I am happy to commend the executive staff for the fine job which they have done. I should also like to compliment the legislative committees and the individual physicians who contacted personally the representatives from their districts. I urge you to read thoroughly material on legislative matters made available to you through *The Journal*, *The OSM Agram* and in special bulletins and to establish personal contact with Ohio Representatives, Ohio Senators and Ohio Congressmen from your district that they may come to you, or receive you, when they need information to guide them in medical matters.

Frank H. Mayfield, M. D.,
President

Fall Postgraduate Courses . . .

A Number of Excellent Programs Are in Store for Ohio Doctors in Various Parts of the State; Available Details on Many of Them Are Reported Here

REFRESHER courses in many areas of Ohio are in store for physicians this Fall. Several District meetings are scheduled, as well as programs sponsored by metropolitan area societies. The list also shows several state-wide meetings and some national organizations meeting in Ohio with excellent programs.

Here is the list of meetings announced before this issue of *The Journal* went to press, followed by details of speakers, programs and other features in store for physicians (arranged in chronological order):

September 16-17—Ohio Academy of General Practice, Annual Scientific Assembly, Columbus.

September 25-26—Course in Pulmonary Diseases, Ohio State University College of Medicine, Columbus.

October 7—Northwestern Ohio Medical Association, Findlay.

October 7—Symposium on Therapy of Acute Injuries, AMA Council on Drugs, Cleveland.

October 8—Eighth Councilor District Program, Lancaster.

October 15-17 — Academy of Psychosomatic Medicine, Cleveland.

October 21—Columbus Academy of Medicine, Clinic Day, Columbus.

October 21—Second District Postgraduate Program, Springfield.

October 21—Sixth District Postgraduate Day, Warren.

November 18-19 — Cleveland Academy of Medicine, Seminar on Recent Advance in Diagnosis and Therapy of Malignant Diseases, Cleveland.

* * *

Ohio Academy of General Practice Meets in Columbus Sept. 16-17

The Ohio Academy of General Practice will hold its Ninth Annual Scientific Assembly in the Veterans Memorial Building, Columbus, on Wednesday and Thursday, September 16 and 17. The program is acceptable for 10 hours Category I Credit for AAGP members. The program has been announced as follows:

Wednesday, September 16

9:00 A.M.—Specific Problems Pertaining to the Practice of Industrial Medicine—panel.

Joseph A. Solomayer, M.D., Cleveland, Moderator

Occupational Dermatoses—Donald Birmingham, M.D., Cincinnati

Common Psychiatric Diagnoses Encountered in Occupational Medical Practice—Donald Ross, M.D., Cincinnati

The Control of Some of the Major Health Hazards in Ohio — Thomas F. Mancuso, M.D., Columbus

Medicolegal Aspects of Industrial Practice —Mr. William C. Hartman, Attorney, Cleveland

Question and Answer Period

10:30—Visit Exhibits

11:15—Hepatitis—Leon Schiff, M.D., Cincinnati

12:00—Lunch and Visit Exhibits

1:00 P.M.—Office Suturing — John Kelleher, M.D., Toledo

1:30—Common Surgical Emergencies—A. Lee Lichtman, M.D., New York City

2:00—When to Refer the Cardiac for Surgery —Bernard L. Brofman, M.D., Cleveland

2:30—Visit Exhibits

3:15—Hematuria in Benign Conditions—Edwin P. Alyea, M.D., Durham, North Carolina

4:00—Chemotherapy of Cancer—John R. Keys, M.D., Dayton

6:00—Social Hour and Dinner-Dance. Why We Laugh—Wm. Craig, Ph.D., Wooster

Thursday, September 17

9:00 A.M.—Examination of the Back—Jos. T. Leach, M.D., Columbus

9:30—GP's Approach to the Parkinsonian Patient—Kenneth H. Abbott, M.D., Los Angeles

10:00—The Allergic Patient, his Problems, Office Diagnosis and Treatment—John Burger, M.D., Birmingham, Michigan

10:30—Visit Exhibits

11:15—Anticoagulant Therapy—Gordon Todd, M.D., Toledo

12:00—Lunch and Visit Exhibits

1:00 P.M.—Diagnosis, Management and Pre-

(Continued on Next Page)

vention of Rheumatic Fever—Don M. Hosier, M.D., Columbus

1:30—New Concepts in Neonatal Jaundice—Warren E. Wheeler, M.D., Columbus

2:00—Care of Preschool Child—Thomas E. Shaffer, M.D., Columbus

2:30—Visit Exhibits

3:15—Diuretics—Kathryn Dustan, M.D., Cleveland

3:45—Management of Frustration in Everyday Practice—Victor Szyrnski, M.D., Ottawa, Canada

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Course in Pulmonary Diseases Scheduled at Ohio State

General practitioners will receive special credit from the Ohio Academy of General Practice for a course in pulmonary diseases sponsored by the Ohio State University College of Medicine and four other sponsoring organizations. The course is scheduled on the OSU Campus, Columbus, Friday and Saturday, September 25 and 26.

Sponsors are the Ohio State University College of Medicine, the Ohio State Medical Association, Ohio Trudeau Society, American Trudeau Society, and the Ohio Tuberculosis and Health Association.

Reservations for the course, accompanied by a check for \$25.00 should be sent to: Harold L. Autrey, Treasurer, Ohio Tuberculosis Hospital, Columbus 10, Ohio. Registration is limited to 150 and applications must be received by September 8, 1959.

Hotel reservations should be made with the hotel of choice. The Fort Hayes Hotel has reserved a limited number of rooms until September 8, 1959. (The football weekend makes this early reservation necessary.)

An additional attraction is the Ohio State-Duke University football game on Saturday afternoon, September 26.

The registration fee includes one ticket for the banquet on Friday evening. Extra tickets at \$5 each may be secured for those who wish to bring their wives.

The course has been designed to provide the physician in general practice with current concepts of pulmonary disease, cardiac surgery, and carcinoma with emphasis on practical aspects of diagnosis and treatment.

The banquet speaker will be Richard A. Prindle, M. D., Chief of the Air Pollution Medical Program of the United States Public Health Service. He will discuss air pollution.

Other speakers will include James Monroe,

M. D., Assistant Director of Ray Brook State Tuberculosis Hospital, Ray Brook, New York, who will discuss "Present Status of Chemotherapy"; Katharine R. Boucot, M. D., Professor of Preventive Medicine, Women's Medical College, Philadelphia, "Detection of Curable Lung Cancer"; George W. Wright, M. D., Head of the Medical Research Department of St. Luke's Hospital, Cleveland, "Pulmonary Emphysema"; and H. S. Van Ordstrand, Chief of the Department of Pulmonary Diseases, Cleveland Clinic, "Differential Diagnosis of Pleural Fluids."

Additional speakers will include members of the staff of the Ohio State University College of Medicine and others.

The program will be held in the Ohio Union Conference Theater, Ohio State University, High Street at 13th Avenue. The banquet will be held in the Gold Room, Fort Hayes Hotel, Columbus.

* * *

Northwestern Ohio Medical Association To Meet in Findlay, October 7

The Northwestern Ohio Medical Association, composed of physicians from the Third and Fourth Councilor Districts, will meet at the Findlay Country Club on Wednesday, October 7. Registration will be from 8:30 to 9:45 a. m.

The program has been announced as follows:

9:45 a. m.—Management of Minor Physical and Behavior Problems in Childhood, Dr. Thomas E. Shaffer, professor, Department of Pediatrics, Ohio State University.

10:15—Current Concepts of Diagnosis and Management of Arthritis, Dr. Vol. K. Philips, clinical assistant professor, Department of Medicine, Division of Arthritis and Rheumatic Diseases, Ohio State University.

10:45—Headache, Dr. Harry E. LeFever, professor in the Department of Surgery, Division of Neurosurgery, Ohio State University.

11:15—Abnormal Uterine Bleeding, Dr. William E. Copeland, assistant professor of obstetrics and gynecology, Ohio State University.

12:00 noon—Luncheon, Findlay Country Club. Speaker: Dr. Charles A. Doan, dean of the Ohio State University College of Medicine; Subject: Medical Education and Research as They Apply to the Future Practice of the Art and Science of Medicine.

2:00 p. m.—Symposium on the Selection and Evaluation of Patients:

1. Who May Be Candidates for Cardiac

(Continued on Next Page)

Surgery, Dr. James A. Helmsworth, assistant professor of surgery, and Dr. Samuel Kaplan, assistant professor of pediatrics and fellow in cardiology, University of Cincinnati College of Medicine.

2. **Clinical Pathological Conference Dealing with an Important Problem in the Field of Liver Disease**, Dr. Edward A. Gall, professor of pathology, and Dr. Leon Schiff, professor of medicine, University of Cincinnati College of Medicine.

3. **Diagnosis and Management of Thrombocytopenic Purpura**, Dr. John Will, Assistant professor of medicine, University of Cincinnati College of Medicine.

Sponsors announced that the program is approved for 5 hours of Category I credit for members of the American Academy of General Practice.

* * *

Symposium on the Therapy of Acute Injuries, Cleveland, Oct. 7

A symposium on the Therapy of Acute Injuries is scheduled in Cleveland, on Wednesday, October 7, under sponsorship of the Council on Drugs of the American Medical Association. Co-operating in promoting the symposium are the Ohio State Medical Association, the Academy of Medicine of Cleveland and Cuyahoga County, Western Reserve University School of Medicine and the Ohio Committee on Trauma of the American College of Surgeons.

The program will be in the Auditorium of the Allen Memorial Library, 2009 Adelbert Road. Registration will be open at 9:30 a. m. (no registration fee).

This program was planned by the following Committee: Dr. F. A. Simeone, Chairman, Dr. H. K. Beecher and Dr. P. H. Long, members of the A. M. A. Council on Drugs; Dr. E. C. Weckesser, Chairman of the Academy of Medicine of Cleveland Committee on Trauma and member of the Ohio Committee on Trauma of the American College of Surgeons; Dr. J. H. Davis, Jr., member of the faculty of Western Reserve University School of Medicine.

Advance reservations are required for the luncheon, at \$2.50 each, and should be forwarded, with remittance, prior to October 1, 1959, to Mr. Robert A. Lang, Executive Secretary, Academy of Medicine of Cleveland, 2009 Adelbert Road, Cleveland 6, Ohio (Telephone Cedar 1-3500).

The symposium is acceptable for five hours of

Category II credit for members of the American Academy of General Practice.

The program is as follows:

10:00 a. m.—Welcome:

Dr. Eugene A. Ferreri, President, Academy of Medicine of Cleveland.

Dr. Douglas D. Bond, Dean, Western Reserve University School of Medicine.

Dr. Frank H. Mayfield, President, Ohio State Medical Association.

10:10—Opening Remarks by the Chairman, Dr. F. A. Simeone, member of the AMA Council on Drugs and professor of surgery, Western Reserve University.

10:15—**Fluid Replacement in Shock and Hemorrhage**, Dr. John M. Howard, professor of surgery, Hahnemann Medical College.

10:45—**Emergency Care of Wounds**, Dr. Sam F. Seeley, professional associate, Division of Medical Sciences, National Academy of Sciences, National Research Council.

11:15—**Initial Treatment of Burns**, Dr. Ben J. Wilson, professor of surgery, and chairman of the Department of Surgery, University of Texas Southwestern Medical School.

11:45—**Local and Systemic Antimicrobial Therapy in Injured Patients**, Dr. W. A. Altmeier, professor of surgery and chairman of the Department of Surgery, University of Cincinnati College of Medicine.

12:15—**Management of the Patient with Multiple Injuries**, Dr. Curtis P. Artz, associate professor of surgery, University of Mississippi School of Medicine.

1:00—Luncheon.

2:15—**Control of Pain in Severe Trauma**, Dr. Henry K. Beecher, Door professor of research in anesthesia, and head of the Department of Anesthesia, Harvard Medical School.

2:45—**Early Management of Fractures**, Dr. Oscar P. Hampton, Jr., assistant professor of clinical orthopedic surgery, Washington University School of Medicine.

3:15—**Active and Passive Anti-Tetanus Immunization in Acute Injuries**, Dr. Edward S. Stafford, associate professor of surgery, The Johns Hopkins University School of Medicine.

4:00—Question and Answer Period — Moderator Dr. Simeone.

5:00—Adjournment.

(More Programs on Next Page)

Eighth District Program Scheduled In Lancaster, October 8

The Eighth Councilor District will hold a program and dinner meeting on Thursday, October 8, at the Lancaster Country Club. Final arrangements for the program were being made when this issue went to press. The theme of the program, scheduled from 2 to 5 p. m. will be Cancer. A social hour and dinner will follow the program. The ladies are invited to participate.

The committee on arrangements includes Dr. George F. Jones, Dr. Wilford D. Nusbaum and Dr. William D. Monger, Eighth District Councilor, all of Lancaster.

* * *

Academy of Psychosomatic Medicine Schedules Cleveland Meeting October 15-18

The Academy of Psychosomatic Medicine will hold its Annual Meeting at the Hotel Sheraton-Cleveland in Cleveland on October 15-17. The meeting has been specifically planned for the psychosomatic orientation of the general practitioner, internist, pediatrician, obstetrician, and other non-psychiatric physicians.

There will be five Symposia—with four speakers in each Symposium — on Psychopharmacology, Anxiety, Mental Drug Therapy, Psychotherapy for the Nonpsychiatrist, and Depression. Panel discussions are scheduled on the psychosomatic aspects of gastro-intestinal, arthritis-neuromuscular, and cardiovascular diseases; obesity, obstetrics-gynecology, alcoholism, geriatrics, headaches-migraine, pediatrics, hypnosis, allergy, pre and postoperative care, and malignancy. There will be two panels on The Newer Anti-Depressive Drugs. Program chairman is Dr. Zale A. Yanof, Toledo.

A partial list of the speakers are: Edward Stainbrook, M.D., chief, Department of Psychiatry, Medical School, University of Southern California; I. Arthur Mirsky, M.D., professor of clinical science and research psychology, University of Pittsburgh Medical School; Frank J. Ayd, Jr., M.D., chief of psychiatry, Franklin Square Hospital, Baltimore; David J. Impastato, M.D., associate clinical professor of psychiatry, New York University College of Medicine; C. Knight Aldrich, M.D., chief of psychiatry, School of Medicine, University of Chicago; Victor Szyrnski, M.D., professor of psychotherapy, University of Ottawa Medical School; A Dixon Weatherhead, M.D., chief of psychiatry, Cleveland Clinic; Leo Alexander, M.D., director, neurobiologic unit, Division of Psychiatric Research, Boston State Hospital;

Theodore R. Robie, M.D., president, Eastern Psychiatric Research Association; John M. Mack-

(*Psychosomatic Medicine—Cont'd*)

enzie, M.D., associate professor of psychiatry, Tufts University Medical School, Boston; Arthur L. Scherbel, M.D., head, Department of Rheumatic Disease, Cleveland Clinic and Cleveland Clinic Hospital; Rudolph Bircher, M.D., medical director, Sandoz Pharmaceuticals; Vernon Kinross-Wright, M.D., associate professor of psychiatry, Baylor University College of Medicine, Houston; Charles H. Brown, M.D., head, Department of Gastro-intestinal Diseases, Cleveland Clinic and Cleveland Clinic Hospital; Joseph B. Kirsner, M.D., professor of medicine, School of Medicine, University of Chicago; Milton Plotz, M.D., associate professor of clinical medicine, State University Medical Center of New York; Carl C. Pfeiffer, M.D., professor of pharmacology and director of the Division of Basic Health Sciences, Emory University Medical School, Atlanta;

Theodore Rothman, M.D., associate professor of psychiatry, University of Southern California Medical School, Los Angeles; Arnold P. Friedman, M.D., Associate Professor of Clinical Neurology, Columbia University College of Physicians & Surgeons; Robert D. Mercer, M.D., head, Department of Pediatrics, Cleveland Clinic and Cleveland Clinic Hospital; E. James Anthony, M.D., professor of child psychiatry, Washington University School of Medicine; Rudolf Dreikurs, M.D., professor of psychiatry, Chicago Medical School; George Crile, M.D., head, Department of General Surgery, Cleveland Clinic and Cleveland Clinic Hospital; Bernard J. Wattiker, M.D., assistant professor of surgery, New York Medical College; Burton Zohman, M.D., clinical professor of medicine, State University of New York College of Medicine;

Howard P. Taylor, M.D., head, Department of Obstetrics, Cleveland Clinic and Cleveland Clinic Hospital; Robert N. Rutherford, M.D., executive editor, *Western Journal of Surgery, Obstetrics and Gynecology*; Ethan Allan Brown, M.D., associate professor of pediatrics, Tufts University Medical College, Boston; Dieter Koch-Weser, M.D., associate professor of medicine, Western Reserve University Medical School, Cleveland; Jack Sheps, M.D., consulting psychiatrist, Manhattan State Hospital; M. Murray Peshkin, M.D., clinical professor of medicine and pediatrics, Albert Einstein College of Medicine, New York; Jacob L. Moreno, M.D., founder and director of the Moreno Institute of Psychodrama and Group Psychotherapy, Beacon, New York; Louis J. Karnosh, M.D., professor of nervous diseases, Western Reserve University School of Medicine, Cleveland; Irvine H. Page, M.D., director of research, Cleveland Clinic

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Foundation; Felix Wroblewski, M. D., associate professor of medicine, Cornell University Medical College and chief, Section of Medical Enzymology, Sloane Kettering Institute, New York—and others of equal renown.

Members of The American Academy of General Practice attending will receive one hour of category II credit for each hour in attendance, Dr. Yanof announced. Added features are breakfasts and luncheons, a dinner-dance with entertainment, and daily tours and social events for doctors' wives. All interested physicians are invited. For further information address inquiries to: Zale A. Yanof, M. D., Program Chairman, Academy of Psychosomatic Medicine, 2282 Ashland Avenue, Toledo 10, Ohio.

* * *

Columbus Academy of Medicine Presents Clinic Day on October 21

The Columbus Academy of Medicine will present its third annual "Clinic Day" on Wednesday, October 21. The place is the Veterans Memorial Building, 300 West Broad Street, Columbus.

Sponsors report that the program is acceptable for four hours of Category I credit for members of the American Academy of General Practice. No charge will be made for registration and advance registration is not required. All house officers and medical students are invited to attend. Invitations have been issued to members of County Societies in surrounding areas to attend and all interested physicians will be welcome.

The program has been announced as follows:

12:30—1:15 p. m.—Registration.

1:15—Call to Order and Business Meeting.

1:30—**Diagnosis and Management of Combined Heart and Lung Failure**, Dr. John B. Hickam, professor and chairman, Department of Medicine, Indiana University Medical Center, Indianapolis.

2:15—**Observations on Staphylococcal Infections**, Dr. David B. Rogers, chairman, Department of Medicine, Vanderbilt University School of Medicine, Nashville, Tenn.

3:30—**Coronary Arteriography by Transcatheter Approach**, Dr. William Molnar, associate professor, Department of Radiology, Ohio State University, Columbus.

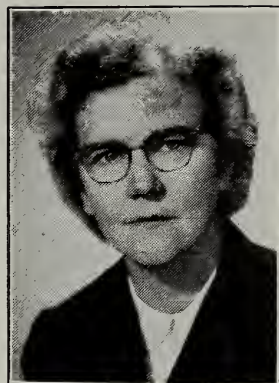
4:15—**Newer Developments in the Therapy of Coronary Disease with Particular Reference to the Diagnosis and Surgical Treatment**, Dr. C. Walton Lillehei, professor, Department of Surgery, University of Minnesota Medical School, Minneapolis, Minn.

5:00—Adjournment.

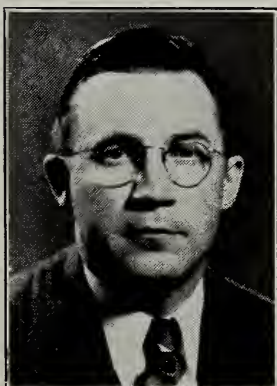
Second District Speakers



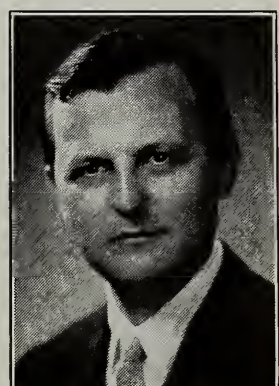
Geo. J. Hamwi, M. D.



Elsie Carrington, M. D.



Harvey Knowles, M. D.



E. S. Crawford, M. D.

Second Councilor District To Meet In Springfield, October 21

The Clark County Medical Society will be host to the Second Councilor District Meeting, Wednesday, October 21, at the Springfield Country Club. Registration begins at 1:00 p. m. A panel discussion is scheduled from 1:30 to 5:00, followed by a social hour and dinner. A short business session will include election of officers.

Present officers of the Second District Society are, Dr. George J. Schroer, Ft. Lorrain, president; Dr. Kenneth D. Arn, Dayton, vice-president; Dr. Frank W. Anzinger, Springfield, secretary; and Dr. William H. Hanning, Dayton, treasurer. Second District Councilor is Dr. Ray M. Turner, Springfield.

Dr. Paul Schanher, Springfield, is chairman of the program committee and Dr. Anzinger is chairman of the arrangements committee. Reservations for dinner should be sent, at \$6.00 each, to Dr. Frank W. Anzinger, 444 West Harding Road, Springfield.

The program has been announced as follows:

Oral Hypoglycemics and Various Enzyme Preparations, Dr. Geo. J. Hamwi, professor of medicine and chief of the Division of Endo-

(Continued on Next Page)

Endocrinology, Ohio State University College of Medicine.

Diabetes in the Adolescent, Dr. Harvey Knowles, University of Cincinnati College of Medicine.

Diabetes in Pregnancy, Dr. Elsie Carrington, Temple University School of Medicine.

Vascular Surgery in Diabetes, Dr. E. Stanley Crawford, Baylor University School of Medicine.

After dinner the foregoing speakers will form a panel to answer questions submitted during the afternoon program.

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Sixth District Postgraduate Day To Be in Warren, October 21

The Sixth Councilor District Postgraduate Day has been announced for Wednesday, October 21, in the Packard Music Hall, Warren. Registration will begin at 9:00 a. m. with the program starting at 9:30.

An outstanding list of speakers who have accepted invitations to participate on the program has been announced by Dr. George A. Sudimack, who is in charge of program arrangements.

The list of speakers includes the following: H. Doubilet, M. D., New York; R. F. Bowers, M. D., Memphis; J. McCaughan, M. D., Memphis; E. L. Weckesser, M. D., Cleveland; G. O. Eaton, M. D., Baltimore; W. Duncan, M. D., Cleveland; V. DeWolfe, M. D., Cleveland; J. Hayman, M. S., Boston; M. Brennan, M. D., Detroit; B. K. Wiseman, M. D., Columbus; E. R. Levine, M. D., Chicago; C. H. Brown, M. D., Cleveland; G. Manson, M. D., Detroit; N. Stahl, M. D., Syracuse; R. L. Denton, M. D., Montreal; A. Lash, M. D., Chicago; L. Israel, M. D., Philadelphia; E. C. Mann, M. D., New York; R. A. Hingson, M. D., Cleveland; H. A. McCann, M. D., Boston.

Exact topics for each speaker were in the planning stage as this issue went to press. The following subject matter, however, gives a cue to the outstanding program in the making: Pancreatitis; Varicose Veins; Hope for the Patients with Metastatic Carcinoma; Fractures of the Forearm, Hand and Foot; Peripheral Vascular Disease—Panel; Kidney Disease; Chemotherapy in Leukemias and Lymphomas; The Failing Lung of Middle and Old Age; Pediatric Parenteral Fluid Therapy; Recurrent Vague Abdominal Pain in Childhood; Hyperbilirubinemia in the Newborn; Complications of Pregnancy—Effect on Mother and Child; Recent Advances in Gynecologic Endocrinology; Lesions of the Cervix; Analgesia and Anesthesia; Clinico-Pathological Panel.

Cleveland Academy To Present Two-Day Seminar on Malignant Diseases

The Academy of Medicine of Cleveland and Cuyahoga County Medical Society will present a two-day postgraduate seminar on "Recent Advances in Diagnosis and Therapy of Malignant Disease" on Wednesday and Thursday, November 18 and 19.

Morning clinics at Cleveland hospitals will be concerned with problems of diagnosis. Afternoon panel discussions on pathogenesis and therapy will be in the Medical Library Auditorium, 2009 Adelbert Road, Cleveland.

Sponsors announce that this seminar has been approved for 13 hours credit in Category I by the American Academy of General Practice.

Registration will be limited by the capacity of the auditorium and enrollment in each of the hospital clinics by hospital facilities. All applications will be processed in the order in which they are received.

Registration fees for Academy members are: \$5.00 for scientific sessions only or \$15.00 for scientific sessions, social hour and dinner. Registration for non-Academy members will be \$10.00 or \$20.00, respectively. Interns and residents will be admitted free to the scientific sessions. Inquiries should be addressed to the Academy of Medicine of Cleveland, 2009 Adelbert Road, Cleveland 6; telephone—CEdar 1-3500.

A complete program will be announced later. The following tentative program has been announced:

Wednesday, November 18

Pathogenesis of Malignant Disease followed by Its Therapy with Radical Surgery and Radiation; Moderator, Dr. Max M. Zininger, professor of surgery, University of Cincinnati.

Pathogenesis of Neoplasia, Dr. Howard T. Karsner, medical research advisor to Surgeon General, U. S. Navy, Washington, D. C. (Sponsored by the Cuyahoga Unit, American Cancer Society.)

Increased Radicality in the Modern Surgical Attack on Cancer, Dr. Alexander Brunschwig, attending surgeon, and chief of gynecological service, Memorial Center for Cancer and Allied Diseases; professor of clinical surgery, Cornell University Medical College, New York City.

Curative Radiotherapy of Malignant Disease, Dr. L. Henry Garland, clinical professor of radiology, Stanford University Medical School.

Dinner at the Wade Park Manor followed by the

(Continued on Next Page)

(Cleveland Academy)—Cont'd)

Annual Lower Lecture. (Open to all physicians.)

Recent Advances in the Study of the Living Cell, Dr. C. M. Pomerat, professor of cytology and director of Tissue Culture Laboratory, University of Texas Medical Branch, Galveston.

Thursday, November 19

Treatment of Malignant Diseases by Hormonal and Chemotherapeutic Agents; Moderator, Dr. L. Henry Garland.

The Search for New Clinical Chemotherapeutic Agents Against Carcinomas and Other Tumors, Dr. Joseph H. Burchenal, chief of the Division of Clinical Chemotherapy, Sloan-Kettering Institute and professor of medicine, Cornell University.

Chemotherapy of Hormone-Producing Tumors of Adrenal and Trophoblastic Origin, Dr. Roy Hertz, chief, Endocrinology Branch, National Cancer Institute, Bethesda, Md.

The Therapy of Leukemia and Leukosarcoma, William Dameshek, professor of medicine, Tufts University School of Medicine, and director, Blood Research Laboratory, New England Center Hospital, Boston, Mass.

AMA Disavows Implied Endorsement Of Vitamin Product

The American Medical Association has recorded an official protest with the Federal Trade Commission against a recent advertisement of the Vitasafe Corporation, a New York City mail-order vitamin house.

In a letter, dated July 21, Dr. Ernest B. Howard, AMA assistant executive vice-president, stated: "In our opinion the Vitasafe Corporation has attempted to imply in this advertisement the endorsement of the American Medical Association of one of their products. The association has not approved this advertisement copy nor has it at any time approved or endorsed in any way the product or products of this organization. This matter is being brought to your attention for whatever action you feel is indicated."

The Vitasafe ad, which appeared in newspapers and magazines, featured a premium give-away offering "The Official AMA Book of Health" plus a 30-day supply of "high-potency capsules." The "Book of Health" which is currently being offered is a collection of articles from *Today's Health*, the consumer magazine of the AMA. The book was published and distributed by the Dell Publishing Company.

New Medicare Directive On Obstetrical Care

A NEW DIRECTIVE has been issued by Medicare which states that in the case of a serviceman's wife who is pregnant at the time of his death, she remains eligible for maternity care at government expense from civilian sources if she was eligible for obstetrical care prior to his death. It became effective July 28.

Blue Cross - Blue Shield Coverage Policy Adopted by Radiologists

At a recent general session of the Ohio State Radiological Society, the membership adopted a resolution relative to Blue Cross and Blue Shield coverage of radiological services on an out-patient basis. Text of the resolution follows:

"We realize that it would be ideal for ambulatory diagnostic and therapeutic radiological services to be insured only in Blue Shield.

"But, we are aware of the fact that it is now covered to a limited extent in Blue Cross in most areas, and, because in some areas there may not be adequate ambulatory radiological facilities available outside of hospital departments, and, because we are aware of the fact that once a service is in Blue Cross it cannot be removed without adequate, proven parallel coverage,

"Be it resolved, That the compromise solution reached in Northeastern Ohio is acceptable to the Ohio State Radiological Society.

"In this solution Medical Mutual and Blue Cross have jointly covered ambulatory radiological services for employees of General Motors Corporation and Ford Motor Company as follows:

"1. Equal benefits are paid regardless of where service is rendered, but available only to those who already have both Blue Shield and Blue Cross coverage.

"2. Payment is to be made by respective agency, depending upon whether the bill is submitted by the hospital or by the radiologist on his own billhead.

"Be it further resolved, That the Ohio State Radiological Society be on record as approving this arrangement and that Ohio Medical Indemnity be requested to enter into the same arrangement with the several Blue Cross Plans—General Motors, Ford, and other employers, who will pay the necessary additional premium, on an agreed fee schedule, but substantially the same as in Northeastern Ohio, where the fee schedule represents the average current fees charged at present in that area."

What The Legislature Did . . .

Detailed Review of What Happened on Record-Breaking Number of Medical, Health and Welfare Proposals During 103rd Session of General Assembly

BY GEORGE H. SAVILLE

Assistant Executive Secretary; Director of Public Relations

MEDICAL and public health legislation was very much in the limelight during the 103rd session of the Ohio General Assembly which adjourned sine die on August 14 to conclude the longest regular legislative session—and one of the most hectic—in Ohio's history.

The 103rd established a number of all-time records, including: The largest appropriation bill in the State's history—\$1.8 billion; a record high allowance of \$413 million for public school subsidies; the levying of the largest amount of additional taxes, and the highest total of bills—1607—ever introduced in a regular session. Approximately 300 were enacted.

Medical-Health Bills Total 160

Some 160 bills affecting the practice of medicine, allied health fields and public health were in the legislative hopper. More than the usual interest in public health measures was generated by Governor DiSalle's special message to the General Assembly on public health legislation. (OSMJ—April, 1959, P. 541) Most of the constructive proposals recommended by the Governor were enacted into law.

All legislation in the medical-health field was closely followed by representatives of the Ohio State Medical Association. Bills were sponsored, supported or opposed, according to the policy of the Association as determined by the House of Delegates or The Council.

Legislative Machinery Clicked

Representatives of the OSMA appeared at many committee hearings in both the Senate and the House of Representatives, testifying either for or against bills, or suggesting amendments for the improvement of proposed legislation.

Each Thursday afternoon a Legislative Bulletin went out from the State Headquarters Office to county medical society officers and legislative chairmen. These bulletins related the status of medical-health bills and made suggestions for follow-up contact with legislators "back home." Special bulletins with specific suggestions for local

action were sent to key areas when the issues got hot. The record shows that the legislative machinery of the State Association and the County Medical Societies functioned very well during the long and arduous session.

Many First Termers

The 103rd was the first Democratic-controlled General Assembly in 10 years. This resulted in a complete change in leadership; an unusually high proportion of first-termers, and all new committee chairmen.

Fortunately, Hon. James M. Lantz, Fairfield County's representative, elected Speaker of the House, demonstrated a keen understanding and interest in medical-health legislation. Much credit for the legislative's creditable record in this field should go to Speaker Lantz and to Hon. Vernon G. Hisrich, Tuscarawas Co., Chairman of the House Health Committee. Rep. Hisrich was ably assisted by Rep. Harold W. Oyster, Washington Co., secretary and former chairman of the House Health Committee.

Senate Situation Difficult

The situation in the Senate was quite complicated and very difficult because of the so-called "King Bill." Sen. Frank W. King, Lucas Co., President Pro-Tem and Majority Floor Leader of the Senate, introduced S. B. 413 to compel hospitals to grant staff privileges to all licensed physicians who had served in the armed forces in World War II or the Korean war. The bill arose out of a situation in Toledo involving Sen. King's personal physician, a graduate of an unapproved medical school who had been licensed in Ohio through special legislation admitting to the medical board examinations Ohio graduates of unapproved medical schools with subsequent military service.

Because of its powerful sponsorship, S. S. B. 413 sailed through the Senate Committee on State Government and finally came up for a vote on the floor of the Senate, July 8. Due to the united opposition of the Ohio State Medical Asso-

Governor Signs H. B. 600, Cancer Registry Bill



Governor Michael V. DiSalle is shown here signing H. B. 600 to protect the confidentiality of reports to cancer registries. Standing with the Governor are, left to right: Dr. Ralph E. Dwork, director of the Ohio Department of Health; Co-authors of the Bill—Sen. J. Sherman Porter, Gallia County, and Rep. John M. Ashbrook, Licking County; and Dr. Arthur D. James, chairman of the OSMA Committee on Cancer.

ciation and the Ohio Hospital Association, most members of the Senate apparently were convinced that the proposed establishment of statutory standards and qualifications for the admission of a physician to hospital staff privileges is not a proper field for legislative action. S. S. B. 413 was defeated 20-9, with four members not voting—the equivalent of a “No” vote. (August OSMJ, P. 1120)

Enabling Act on Medical Care Plans

Another bill originating in the Senate and eventually enacted into law was Amended Substitute Senate Bill 461, an enabling act to authorize corporations not for profit to establish pre-paid health care plans. Sponsored by the Ohio AFL-CIO, United Mine Workers and the Ohio Farm Bureau, AASB 461 follows the consumer-cooperative,

closed-panel principle of such plans as the Health Insurance Plan of Greater New York (HIP), and the Kaiser Foundation on the West Coast.

Although there is nothing in the act which would prohibit any plan organized under its provisions from permitting subscribers to have free choice of physician, the OSMA was unsuccessful in its efforts to have a mandatory free-choice of physician amendment inserted in the bill. However, the bill was amended to include supervision by the State Superintendent of Insurance, and other safeguards comparable to those in the statutes governing Blue Cross.

A complete explanation of Ohio's new medical care plan law and the action of the recent session of the House of Delegates of the American Medical Association on free choice of physician and the relationship between the medical

profession and third-party medical care plans appeared in the August, 1959, issue of OSMJ.

Chiropractic Bill Fractured

The biennial effort of chiropractors to be removed from the jurisdiction of the State Medical Board and be licensed and regulated by a separate board of chiropractors was decisively rejected early in the session by the House Health Committee. H. B. 291 was indefinitely postponed by a vote of 11-1.

H. B. 1079, which proposed the addition of a chiroprodist and a chiropractor to the State Medical Board; annual registration, etc., died in the House Reference Committee, without having even been referred to a committee for a hearing.

Psychology Board Bill Died

S. S. B. 11, to create a state board for the certification and regulation of psychologists, died in the House Health Committee during the rush of the closing days of the session. One of the first bills introduced in the Senate, S. B. 11 was sponsored by the Ohio Psychological Association. The bill was considered by the Senate Judiciary Committee and referred to a subcommittee.

During the hearings before the Judiciary Committee, representatives of the OSMA and the Ohio Psychiatric Association, questioned the necessity for the bill. However, they offered a number of corrective amendments for committee consideration. Some of them were incorporated in the substitute bill drafted by the subcommittee and subsequently recommended for passage by the main committee. S. S. B. 11 was in the Senate Rules Committee from March 24 to July 1 awaiting assignment for a vote in the Senate.

The psychological group put on an intensive and active campaign in behalf of the passage of S. S. B. 11. Their principal contention was the legislation was needed to control the activities of charlatans and quacks in this field. It was pointed out by the opponents that similar legislation in other states had not accomplished that purpose—the charlatans and untrained persons merely changed titles.

The bill exempted from its provisions full-time psychologists employed by governmental agencies, guidance centers and industrial concerns. It would have permitted psychologists to open private offices. Under the present Medical Practice Act, psychologists who wish to practice psycho-therapy can be licensed under the limited practitioner's section.

Amended in Senate

When the bill came up for debate in the Senate on July 2, Sen. Charles J. Carney, Mahoning Co.,

offered an amendment to place the proposed psychologist's board under the jurisdiction of the State Medical Board. Over the vigorous protest of Sen. Oliver Ocasek, Cuyahoga Co., author of the bill, the amendment was adopted 14-9. The bill as amended passed the Senate 19-6, with 8 Senators not voting.

Dissatisfied with S. S. B. 11 as it passed the Senate, the proponents offered the House Health Committee a series of amendments which would have deleted the "Carney amendments" which placed the proposed psychologist's board under the State Medical Board and instead proposed placing it under the Ohio Department of Health. The committee did not act on the amendments, and the bill was pending in the committee when the legislature adjourned.

Medical Practice Act Revised

Three bills were enacted as amendments or additions to the present Medical Practice Act. They were:

H. B. 384 — To increase medical board fees from \$25 to \$50 for examination and from \$50 to \$100 for endorsement of a physician's license in another state. **Effective October 1, 1959.**

At the request of the State Medical Board, the OSMA actively sponsored the bill, which was introduced by Rep. G. D. Tablack, Mahoning Co. Its sole purpose is to provide sufficient revenue to make the Board self-sustaining. Fees for examination and endorsement had been unchanged since set by statute in 1900. In recent years the Board's revenue has been considerably less than its cost of operation.

S. S. B. 315 — To provide for the licensure of physical therapists under the jurisdiction of the State Medical Board. **Effective October 8, 1959.**

Sponsored by the Ohio State Chapter of the American Physical Therapy Association, this bill as introduced would have created a State Board of Physical Therapy Examiners. Advised that the OSMA would oppose the establishment of a new and separate board, the proponents agreed to a substitute bill placing the licensure of physical therapists under the State Medical Board. The measure provides for a Physical Therapy Advisory Committee, appointed by the Medical Board, consisting of five physical therapists and two licensed physicians. The act requires that a licensed physical therapist must practice "upon the prescription and under the direction of a person licensed and registered in this state to practice medicine and surgery." A number of physicians specializing in physical medicine and orthopedic surgery sup-

ported the physical therapists in urging the passage of this bill.

S. S. B. 57 — To place in the Medical Practice Act the present rules and regulations of the State Medical Board governing the practice of chiropody/podiatry. Inasmuch as the bill did not change the scope of practice granted chiropodists and continues them under the jurisdiction of the State Medical Board, the OSMA offered no objection to its passage. **Effective August 24, 1959.**

Cancer Reporting Measure

H. B. 600 — To provide that physicians and others who report cases of malignant disease and supply data thereon to the Ohio Department of Health or to cancer registries which in turn report to the Department shall not be deemed to have violated the laws on confidential relationship or betrayal of a professional secret. This bill was sponsored by OSMA, with the support of the Ohio Department of Health, Ohio Chapter, American Cancer Society, Ohio Hospital Association and the Ohio State Dental Society.

Considerable progress has been made by various voluntary and official health and medical organizations in gathering statistics on cancer. However, personnel engaged in working out cooperative plans with existing local registries and engaged in trying to encourage more local areas to establish a local registry, ran into a legal problem, namely: The reluctance on the part of hospital authorities and a considerable number of physicians to report cancer data for transmittal to the central cancer registry in Columbus, for fear of being charged with violation of the prohibition against revealing professional information.

H. B. 600 does two things: (1) provides that the information assembled will be regarded as strictly confidential, and (2) that any organization or person filing the required cancer data directly with the State Department of Health or with a local registry which in turn reports to the State Department of Health, shall be exempt from liability under the law regarding confidential communications. **Effective October 9, 1959.**

Study of Health Laws Authorized

H. R. 193, approved by the House of Representatives, requests the Legislative Service Commission to make a study of state laws governing the organization and financing of general health districts. This resolution, sponsored by OSMA, arose from action by the House of Delegates at the 1958 Annual Meeting in Cincinnati, at which the Butler County Medical Society pointed out the need for revamping of laws governing general health districts. Similar studies in other government

fields have been suggested by the Legislature. **H. R. 193** was supported by various public health groups. If the Commission decides to make the study as requested, it will report its findings and recommendations to the 104th Ohio General Assembly not later than January 15, 1961.

School Immunization Law

Am. H. B. 323, Ohio's new law to provide that all school children, unless their parents file written objection, must be immunized against polio, smallpox, diphtheria, whooping cough and tetanus in order to be admitted to school, became effective July 7, 1959, as an emergency measure.

(For the text of this law and a memorandum on the subject from Dr. Ralph E. Dwork, Ohio Director of Health, to all local health commissioners, see August, 1959, OSMJ, pp. 1134-6.)

As introduced by Rep. Wm. P. Day of Cuyahoga Co., at the suggestion of *The Cleveland Press* and with the support of the Cleveland Academy of Medicine, H. B. 323 pertained only to compulsory immunization against polio as a pre-requisite to admittance to school. Sentiment grew in the legislature for the inclusion of other immunization procedures. The House Health Committee recommended the bill for passage requiring only polio immunization. The majority of the Committee expressed a belief in local autonomy under the present law, Section 3313.67, which gives local boards of education the authority to require immunization against all communicable and infectious diseases.

However, **Am. H. B. 323** was amended in the House to add immunization against smallpox, diphtheria, pertussis and tetanus, and passed 118-5, after some haggling over the provision for objection by parents. It had easy sailing in the Senate. **Am. H. B. 323** is probably the most comprehensive, compulsory school immunization law in the country. It had the support of the OSMA.

Radiation Protection Measure

Most of the constructive proposals contained in the legislative program of the Ohio Department of Health and recommended by Governor DiSalle in his special message on public health to the General Assembly were approved by the legislature. Those enacted were:

S. H. B. 410 — Relative to radiation protection and to the functions, powers and duties of the Ohio Department of Health for the prevention and prohibition of improper radiation. The act provides:

- The Ohio Public Health Council may adopt regulations necessary to identify, prohibit and prevent improper radiation, including the registration

of persons with the State Director of Health, who produce, use, store or dispose of radiation sources.

- In adopting such regulations, the Public Health Council may exempt certain sources of radiation which do not present a public health hazard, and shall not formulate more restrictive standards than those established by the Federal Government.

- It is also stipulated that in formulating such regulations, due consideration shall be given by the Ohio Public Health Council to standards recommended by nationally recognized authorities in the field of radiation protection.

- The Ohio Director of Health is vested with responsibility for the administration and enforcement of the new radiation-protection law, and regulations adopted by the Ohio Public Health Council.

- The Director is to appoint subject to the approval of the Governor a radiation advisory council, which shall consist of the five individuals of recognized ability, each representing one of the following fields: radiation physics; radiation protection; medicine, with experience in radiation problems; atomic energy, and industrial application of radiation devices.

- The Radiation Advisory Council is to consult with the Ohio Department of Health in matters of policy affecting the administration and enforcement of the Radiation-Protection act, and in the development of regulations. The bill had OSMA endorsement. **Effective November 4, 1959.**

Poison Control Law

S. S. B. 440 — Relative to the labeling of packages of hazardous substances intended or suitable for household use, including packages for use in the home, schools, hospitals, apartment and office buildings, hotels, restaurants and similar places.

This act is an adaptation of the model "Uniform Hazardous Substances Act" developed by the American Medical Association, through its Committee on Toxicology, and the "Hazardous Substances Labeling Act" adopted by four chemical industry trade associations. A similar bill, H. R. 7352, formulated by the A. M. A. is pending in the U. S. Congress. A study of the need for legislation of this type in Ohio was recommended in a resolution adopted by the House of Delegates of the Ohio State Medical Association, at the meeting in Cincinnati, April 17, 1958. S. S. B. 440 had the support of the OSMA.

- The responsibility for administration of the act is placed in the Ohio Director of Health.

- It requires informative precautionary label-

ing of hazardous substances intended or suitable for household use.

- Each container of a hazardous substance must, on its labels state, among other things, the name of the hazardous ingredient, which will facilitate treatment in case of accidental injury.

- The label must also contain a signal word—POISON, DANGER, WARNING, or CAUTION—a statement of the hazard, and a statement of measures to be taken or acts to be avoided in the handling, use and storage of the product.

- Every container of a hazardous substance must carry on its label the statement "Keep out of the Reach of Children," or its practical equivalent.

- The bill also incorporates sound and useful enforcement tools. The Director or his agents may (1) embargo misbranded hazardous substances when he finds or suspects them of being so misbranded as to present a health hazard, (2) apply to a court for condemnation or relabeling, (3) apply to a court for injunctive relief, and (4) institute criminal prosecution for violation. **Effective November 4, 1959.**

Health Agency Merger Bill

A. H. B. 142 — To facilitate the combination of city and county health districts, and the representation of the areas involved on the combined board of health. One of the members of the combined board must be a physician. **Effective July 7, 1959.**

S. B. 232 — To give the Ohio Director of Health, city or district board of health, authority to require vaccination of all dogs for rabies within a district or part thereof where a rabies quarantine has been declared. **Effective September 18, 1959.**

H. B. 526 — To provide for a program of education and research on alcoholism in the Ohio Department of Health. **Effective October 15, 1959.**

S. B. 228 — To permit a probate judge to hold a hearing in the hospital rather than in his court for a patient in the recalcitrant tuberculosis unit of the hospital. **Effective November 2, 1959.**

S. B. 231 — To legalize in state tuberculosis hospitals a welfare fund obtained from the profits of a commissary, to purchase necessary items for needy patients, such as eyeglasses and dentures which are not provided for in other funds. **Effective October 22, 1959.**

Closure of TB Hospitals

Two bills pertaining to the conversion or closure of county and district tuberculosis hospitals were enacted by the 103rd Ohio General Assem-

bly. These bills were sponsored by the Ohio Tuberculosis and Health Association, supported by the Ohio Department of Health, public health organizations and the OSMA. They are:

S. B. 3 — To permit county and district tuberculosis hospitals to accept patients with other diseases for treatment when beds are available, subject to the rules and regulations of the Ohio Department of Health. **Effective July 15, 1959.**

S. B. 4 — To provide a standard procedure for closing of county and district tuberculosis hospitals when no longer needed. **Effective July 15, 1959.**

Two other bills were enacted in this field:

H. B. 146 — To permit the use of tuberculosis levy funds for tuberculosis clinics. **Effective July 28, 1959.**

S. B. 63 — To permit approval of health, education and welfare levies by majority vote, except at special elections. **Effective September 14, 1959.**

The nine bills just referred to had the support of the OSMA.

Workmen's Compensation Hassle

One of the most bitterly contested bills during the session was **H. B. 470** which proposed to abolish the Bureau of Workmen's Compensation, return the State Industrial Commission to the administrative position which it held prior to 1955, increase benefits drastically and in general liberalize the provisions of the Ohio Workmen's Compensation Act. Various labor organizations and a group of attorneys who specialize in representing claimants fought vigorously for the bill as introduced. Representatives of business and industry insisted that the proposed changes in the law would place an enormous burden on employers and would result in a mass of costly litigation.

The majority leadership in the House—Speaker Lantz and Rep. Jesse Yoder, Montgomery Co., majority floor leader; Governor DiSalle, Sen. C. Stanley Mechem, Athens Co., minority floor leader in the Senate; and Rep. Roger Cloud, minority floor leader in the House were in agreement that **H. B. 470** was far too drastic.

After extensive hearings, the coalition of Republicans and less-liberal Democrats prevailed, as it did in other legislation during the session. **H. B. 470** increases benefits to injured workmen from a maximum of \$40.25 to \$49 weekly and death benefits from \$12,000 to \$18,000 maximum. The Bureau of Workmen's Compensation was retained.

Assures Free Choice of Physician

Of particular interest to physicians is a section in the bill by which injured employees of self-

insurers are permitted free choice of physician. The section, as amended, now reads as follows:

"Any employee who is injured or disabled in the course of his employment shall have free choice to select such licensed physician as he may desire to have serve him, as well as medical, surgical, nursing, and hospital services and attention, regardless of whether or not his employer has elected under section 4123.35 of the Revised Code, to furnish medical attention to injured or disabled employees. In the event the employee of a self-insurer selects a physician or medical surgical nursing and hospital services and attention rather than have them furnished directly by his employer the costs of such services subject to the approval of the commission shall be the obligation of such employer."

The new law becomes effective November 2, 1959.

Medical Education Survey

Governor DiSalle is empowered by **S. B. 211** to provide for a survey of current medical education including the desirability of establishing additional state medical colleges in Ohio. It was endorsed by the OSMA. The bill stipulates that "the survey shall, if a need for more medical educational facilities is found, study the methods by which adequate medical education may be provided, including a survey of the most desirable sites. The findings of the survey are to be reported directly to the Governor.

This bill was sponsored in the legislature by the Montgomery County delegation, having in mind the possible location of a medical school in Dayton in connection with the medical center being established there through the generosity of the late Charles F. Kettering. **Effective August 11, 1959.**

Nursing Home Legislation

A long over-due change in Ohio's system for the licensure, regulation and supervision of nursing and rest homes was accomplished by the enactment of **H. B. 245**, which places that responsibility in the Ohio Department of Health, instead of in the Department of Public Welfare. This legislation was initiated by a legislative committee working in conjunction with the Legislative Service Commission on a special study of this important problem. The Ohio Association of Nursing Homes, various civic groups, ODH and OSMA urged passage of the bill. **Effective September 7, 1959.**

The Ohio Public Health Council is vested with the responsibility of making uniform rules and regulations and establishing standards governing the institutions covered by the act. The Ohio Director of Health is given broad enforcement

provisions. The licensing fees for any one institution shall not exceed \$100 annually.

An institution coming under the provisions of H. B. 245 is defined in Sec. 3721.01 as follows: "An institution, home, place of domicile, or other facility in this state which, for a consideration, provides personal assistance to persons, other than individuals who are related to the owner or operator by blood or marriage within the third degree of consanguinity, who are dependent upon the services of others, or which provides skilled nursing and dietary care for persons who are ill or otherwise incapacitated, or which provides services for the rehabilitation of persons who are convalescing from illness or incapacitation, and which is not an institution subject to sections 3701.1 to 3701.84, inclusive, and 3701.99 or sections 5123.01 to 5123.62, inclusive, and 5123.99 of the Revised Code."

Such institutions are classified as follows:

- Institutions which provide personal assistance to persons who, by reason of age or infirmity, are dependent upon the services of others are rest homes.

- Institutions which provide skilled nursing and dietary care for persons who are ill or incapacitated or service for the rehabilitation of persons who are convalescing from illness or incapacitation are nursing homes.

Nothing contained in sections 3721.01 to 3721.09, inclusive, of the Revised Code, or the rules and regulations adopted pursuant thereto, is to be construed as authorizing the supervision, regulation or control of the spiritual care or treatment of residents or patients in any home or institution who rely upon treatment by prayer or spiritual means in accordance with the creed or tenets of any recognized church or religious denomination.

The public health council may further classify such institutions.

Section 3721.02 states that no institution defined in section 3721.01 shall:

- Maintain facilities for the performance of surgery;
- Maintain a clinical laboratory or facilities for diagnostic or therapeutic X-Ray;
- Maintain an emergency ward;
- Accept or treat out-patients;
- Accept, treat, or house persons suffering from contagious diseases or active pulmonary tuberculosis, maternity cases, boarding children, or transient guests.

H. B. 246, a companion bill to H. B. 245, limits the jurisdiction of the Ohio Division of Mental Hygiene to hospitals for the care and treat-

ment of the mentally ill. Effective September 7, 1959.

Other Bills Enacted

Among other bills enacted in the medical-health field were the following:

H. B. 1 — To increase the salaries of appointive state officials, including the Ohio Director of Health from \$12,000 to \$18,000; supported by OSMA. Effective April 13, 1959.

H. B. 69 — An enabling act for the establishment of non-profit dental care corporations. Effective November 2, 1959.

H. B. 72 — Removes the restriction on the issuance of marriage licenses to epileptics; supported by OSMA. Effective October 9, 1959.

H. B. 440 — To allow expenditures from a county hospital operating fund for the purchase of equipment and construction of improvements. Effective November 4, 1959.

H. B. 785 — To strengthen enforcement of the narcotic code, including the requirement that owners of pharmacies maintain a record of their sales of narcotic drugs heretofore exempted. There is no change in the code as it affects physicians; supported by OSMA. Effective October 22, 1959.

Salary Increase for Coroners

S. B. 34 — To increase the salaries of all elective county officials, including county coroners. The range of coroner's salaries previously from \$700 to \$8,700 depending on the county population, now runs from \$800 to \$13,500. Increases will not be effective for county officials during their present term of office. A state law prohibits raises in the middle of a term. Incumbents will get the increase if they are re-elected, or, in case of a death or resignation, the new appointee gets the increased rate. Effective November 6, 1959.

OSMA favored increases for coroners, supporting this bill and H. B. 501, referring only to coroners, which was not enacted.

S. B. 116 — Makes permanent the present temporary law authorizing county commissioners to construct and lease hospital facilities after approval of a bond issue by majority vote; approved by OSMA. Effective September 18, 1959.

S. B. 44 — To remove the ceiling on aid for the aged payments. Instead of a maximum of \$65 per month, pensions will be based on need. The act also removes the requirement that applicants for aid for the aged and aid for the blind must be citizens of the United States, and permits the granting of such pensions after three years residence in Ohio instead of five years—the previous requirement. Effective November 2, 1959.

S. B. 46 — Increases per diem compensation of

members of general district boards of health from three to six dollars and mileage from five to eight cents for not to exceed 12 meetings in any one year. **Effective September 3, 1959.**

Vital Statistics Procedures

S. B. 269 — To prevent unauthorized persons from issuing copies of certain records of vital statistics and to make procedural changes in the method of recording certain vital statistics; supported by OSMA.

These changes in the Vital Statistics statutes were requested by the Ohio Department of Health. Instances had arisen where enterprising individuals had been issuing and selling what were purported to be copies of certificates of birth. Under the new law only persons specifically authorized by law will be permitted to issue such documents.

The procedural changes include: removing the definition of "stillbirth" from the law and delegating that responsibility to the Ohio Public Health Council; arrangement for the filing of a provisional certificate of death by the local registrar to facilitate the issuance of a burial or burial-transit permit in cases where medical certification as to the cause of death cannot be provided by the attending physician or coroner, prior to burial, for sufficient cause. **Effective September 28, 1959.**

Fraudulent Advertising

S. B. 283 — To authorize state boards, commissions and agencies to suspend the license of any person found guilty of fraudulent advertising. This bill, sponsored by the Ohio Newspaper Association, also prevents such state agencies from making rules which would limit or restrict the right of any person to advertise, except as otherwise expressly provided by law existing as of the effective date of the Act. **S. B. 283** does not affect the prohibitions against fraudulent advertising contained in the Medical Practice Act. **Effective November 2, 1959.**

S. B. 460 — To permit mentally ill patients to enter state institutions voluntarily, without formal commitment by the probate court, under certain conditions. **Effective November 9, 1959.**

S. R. 65 — Requests the Legislative Service Commission to make a thorough investigation and study of all phases of the activities of the various state licensing boards, with priority and special attention to be given to the licensing activities of the Accountancy Board.

H. R. 74 — Requests the Legislative Service Commission to study the migrant worker problem.

Hospital Immunity Bill Vetoed

S. S. B. 241, designed to limit the liability of

non-profit organizations, such as hospitals, colleges, YMCA's, etc., for the negligence of employees and agents was vetoed by Governor DiSalle. The bill had passed the Senate 29-1 and the House 93-32. However it failed to muster the needed three-fifths majorities in both Houses to override the Governor's veto. The senate overrode 25-4, but the House fell 21 votes short of the needed 84 in a 63-22 vote late on the night of August 14—the last day of the session—with about 50 members absent.

Sponsored by the Ohio Hospital Association, the purpose of **S. B. 241** was to offset the effect of the 1956 Ohio Supreme Court decision in the case of *Avellone vs. St. Johns Hospital* which held that a non-profit hospital is liable for the negligence of its employees. This denied such institutions immunity which had been in existence for over 100 years.

In a lengthy veto message, The Governor said he was motivated by "the need for the protection of the individual who is injured . . . and whose injury may be so extreme as to deprive him of being able to earn a livelihood, regardless of whether the negligence was gross or de minimus." He added: "The whole theory of the exemption of charitable organizations has changed in our lifetime. We have arrived at a point where insurance against loss is available at a very small cost."

Those Which Died

In addition to the bills previously reported, quite a number of medical-health bills "died in committee," many without a hearing. Some of these proposals represented a whim of a legislator or one of his constituents. All bills deemed unnecessary or detrimental to the public health and welfare were actively opposed by the Ohio State Medical Association. Included among the bills that fell by the wayside were the following:

H. B. 117 — To require that the physical examination of a school bus driver be conducted by a physician other than the driver's personal physician.

H. B. 25 — To amend existing statutes regulating the distribution of drugs intended for prevention of conception or for causing abortion and the publication of literature on such subjects.

H. B. 685 — To permit boards of education to appoint one or more school optometrists (they may now appoint, physicians, dentists and nurses).

H. B. 907 — To remove the one-year statute of limitation on malpractice suits.

H. B. 697 — To eliminate the requirement that

the health commissioner of a general health district be a physician.

Regarding Prescriptions

H. B. 1002 — To require that all prescriptions and labels on drugs and medicines be in the English language and state the contents and purpose on each container.

H. B. 758 — To appropriate \$100,000 to the Ohio Department of Health to provide free polio vaccine for all children under the age of 18.

H. B. 399 — To require reporting of gunshot wounds and other wounds by a deadly weapon, to the sheriff or local police department.

H. B. 215 — To empower local health districts to regulate air pollution.

H. B. 569 and H. B. 1061 — To provide for a uniform state meat inspection service.

Reorganization Proposal

H. B. 1053 — To place the various state independent boards and commissions under major state departments for administrative purposes, the State Medical Board under the Ohio Department of Health.

H. B. 501 — To increase the salary of county coroners. (These salaries were increased along with those of other elected county officials by S. B. 34, but not as substantially as proposed in H. B. 501.)

S. B. 56 — To add temporary disability benefits to the provisions of the Unemployment Compensation Act—compulsory sickness insurance.

S. B. 102 — To provide a standard blood test for drunken drivers.

S. B. 70 — To establish a state board of registration for sanitarians.

S. B. 284 — To reimburse hospitals for deficits in the operation of schools of nursing up to \$250 yearly per student nurse.

S. B. 390 — To split the Department of Mental Hygiene and Correction into two departments.

More Details In Later Issues

The Journal will publish in later issues detailed explanations of the more important measures enacted and also rules and regulations adopted by administrative agencies after bills become effective.

Also, to be included in a subsequent issue will be an analysis of the General Appropriations Bill as it affects the Ohio Department of Health, Division of Aid for the Aged and other agencies which involve the practice of medicine and public health.

Do You Know?...

The American Red Cross has officially approved the mouth-to-mouth artificial respiration method as the best.

* * *

Thomas G. Hull, Ph. D., who has been director of scientific exhibits and secretary of the Council on Scientific Assembly of the AMA since 1930, will retire December 31 and will be succeeded by Col. Charles H. Bramlitt (MC), who retired recently as director of professional services, Office of Surgeon General, U. S. Air Force.

* * *

Dr. Robert T. Stormont, director of the Department of Therapy and Research of the AMA, has resigned to engage in other activities after nine years with the AMA as secretary of the old Council on Pharmacy and Chemistry.

* * *

The American Goiter Association is again offering the Van Meter Prize Award for papers on the thyroid glands. Inquiries should be directed to John C. McClintock, M. D., Secretary, 1491½ Washington Ave., Albany 10, N. Y.

* * *

Dr. Albert Sabin, Cincinnati, in June received the University of Chicago's 1959 Howard Taylor Ricketts Memorial Citation for basic contributions to science through his development of oral vaccine. Dr. Jonas Salk was given the same award in 1957.

* * *

Dr. Edward C. Rosenow, Jr., executive director of the Los Angeles County Medical Association, has announced his resignation to accept the position of executive director of the American College of Physicians, with headquarters in Philadelphia. His appointment is effective September 1.

* * *

A quick-reference emergency service manual has been published by the University of Illinois Hospital, under the editorship of Dr. John H. Schneewind, associate professor of surgery and chief of the emergency service at the institution. Copies are available at \$2.50 from the Student Supply Store, University of Illinois Hospital, 840 S. Wood St., Chicago.

* * *

Dr. George M. Wheatley, third vice-president of the Metropolitan Life Insurance Company, has been named head of the company's Health and Welfare Division. Dr. Wheatley is known in the profession among other things for his work in the field of pediatrics particularly in regard to accident prevention and poison control.

Vaccines for New Program . . .

Bulletin Issued by Ohio Department of Health Relating to Policy Regarding Furnishing of Biologicals for New School Children Immunization Program

ANOTHER bulletin to local health commissioners regarding Ohio's new compulsory school children immunization law was issued on August 10 by Dr. Ralph E. Dwork, state director of health. The first bulletin on this subject was issued on July 9 by Dr. Dwork, the text of which was published in the August issue of *The Journal*, pages 1134-1135.

Dr. Dwork's bulletin of August 10, relating to vaccines supplied to local health departments by the Ohio Department of Health, read as follows:

Text of Bulletin

Within the scope of available funds the Ohio Department of Health for many years has supplied local health departments with several commonly used biologicals without charge for use in local child health programs. These biologicals include (1) combined diphtheria-tetanus toxoids with pertussis vaccine (DPT); (2) combined standard diphtheria-tetanus toxoids (DT); (3) smallpox vaccine; and (4) typhoid vaccine. In the past it has been possible to meet the local demands without too much difficulty since some areas had only modest programs, while others chose to purchase these products with local funds.

The passage of the law this year requiring compulsory immunization of school children, without providing additional funds, will increase the financial burden of many local health departments. It is only natural that several of them have already requested unduly large quantities of vaccines from us in the hope of getting at least a portion of their orders filled. If the amount of biologicals requested exceeds that which we can purchase from available funds, it will be necessary to resort to an allotment system. This we would hope to avoid through your cooperation and judicious review and screening of your needs.

Although most of the products except smallpox vaccine do have long expiration dates, it will serve no purpose to order biologicals if there is no intent or need to use them. It should be remembered that by the time the smallpox vaccine reaches you, it will have less than a 90 day expiration date on it.

What Will Be Available

1. Additional funds are being made available to purchase increased amounts of DPT, standard

DT, and smallpox vaccine. A new biological will also be supplied, namely "adult" diphtheria-tetanus toxoids (adult DT). (Available after September 1, 1959.)

2. A basic allotment of DPT and smallpox vaccine will be available to health departments to continue their operation of "keep well" programs for infants and small children under four years of age. The quantities of these vaccines for each health department will be based on the number of children under four immunized by that health department as reported in the 1958 Health Services Report. This will aim at protecting such programs where they are already in progress.

3. Typhoid vaccine and silver nitrate will be distributed as before.

4. No poliomyelitis vaccine will be available for distribution.

May Have To Pro-Rate

In comparing the requisitions for vaccine in 1958 with the Health Services Report in respect to the number of immunizations performed by local health departments in all age groups, it becomes obvious that many health departments had ordered materials far in excess of their own use. This is perhaps due to the re-distribution to private physicians for use without charge for the materials. Such jurisdictions are likely to receive smaller amounts of certain biologicals.

Hope To Cover 15 Per Cent

Preliminary estimates indicate that the vaccine supplied from state sources to local departments should be sufficient to give basic immunizations to approximately 15 per cent of the school population. We hope that more might become available later on. Many immunizations will be performed by private physicians. Coupled with numerous prior programs, the judicious use of these materials should go far to improve the immunization status of Ohio's children.

These preliminary estimates are based on the recommendations that:

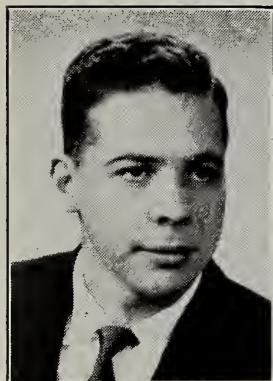
1. Children under 8 years receive DPT.
2. Children 8-13 receive standard DT.
3. Children 14 and older receive "adult" DT. (Available after September 1st).
4. All children receive smallpox vaccine.

Rural Medical Scholarship Winner . . .

Miami County Medical Student Is Chosen To Receive OSMA's Eleventh Annual Award; Will Be Aided Through Four Years of Medical School

SCHOLASTIC achievement in high school and college plus leadership in rural organizations and activities have brought Delbert L. Booher, of Troy, Route 1, Miami County, the Ohio State Medical Association's \$2,000 Rural Medical Scholarship.

Booher will begin his medical studies at The Ohio State University College of Medicine this month. He plans to become a rural general practitioner. Having completed his premedical education at Ohio State in June, he was selected in a competition among young men and women from Ohio's rural communities.



Delbert Booher

The chairman of the scholarship committee, Dr. J. Martin Byers, of Greenfield, said the committee found Booher to be outstanding in the six categories in which applicants are judged: character and integrity, interest in rural activities and organizations, leadership, scholastic ability, native intelligence and mature personality. Other members of the committee include Drs. L. W. High, Millersburg, Kenneth Taylor, Pickerington, and Jasper M. Hedges, Circleville.

Booher has been active in 4-H, Grange, Farm Bureau, church work, Future Farmers of America and the Miami County Junior Fair Board. While maintaining a high scholastic record, he worked to earn 70 per cent of his expenses incurred in obtaining his premedical education.

He is a son of Mr. and Mrs. Charles E. Booher.

The scholarship is administered through the OSMA Committee on Rural Health, of which Dr. Robert E. Reiheld, Orrville, is chairman. The scholarship committee is made up from members of the Rural Health Committee.

The winner receives \$500 annually during his four years of medical school.

Purpose of the annual award, started in 1948, is to stimulate among young men and women from rural areas interest in the study of medicine,

in the belief that they eventually will engage in practice in rural communities.

Previous scholarship winners include: (1949) C. Craig Wright, Winterset, Guernsey County; (1950) Robert G. Smith, Proctorville, Lawrence County; (1951) Donald Nikolaus, Johnsville, Morrow County; (1952) J. Daniel Timmons, New Madison, Darke County; (1953) Raymond Cole, Findlay; (1954) M. Robert Huston, Millersburg, Holmes County; (1955) Ronald D. Moore, New Carlisle, Clark County; (1956) Edwin L. Eakin, Canal Winchester; (1957) William A. Hutchison, Smithville, Wayne County; (1958) Glenn Hisrich, Stone Creek, Tuscarawas County.

Some 55 Million People Covered By 83 Blue Cross Plans

More than 55 million persons now are enrolled in 83 Blue Cross Plans in the United States, Canada and Puerto Rico, the Blue Cross Commission reported recently.

In 1936, when local Blue Cross Plans first began reporting statistics to a national office, about 608,000 persons were enrolled.

The Commission reported that for 1958, total subscriber income amounted to \$1,400,917,900, with \$1,357,392,014 paid out in hospital payments and an administration expense of \$82,762,574. The \$39,236,688 deficit was taken from reserves.

Of the 55 million persons covered, 22 million are subscribers and 33 million are dependents of subscribers.

The commission reported, "Blue Cross was called on by members 10,088,504 times last year to help pay for the cost of their hospital care. They spent, on a national basis, a total of 57,530,459 (hospital) days being cared for—nearly two million more days than in 1957.

"Never before have so many days of hospital care been used by Blue Cross members and never before have so many Blue Cross members used hospital services during a single year."

The commission reported a hospital admission rate of 184 per 1,000 members, 1,042 days of hospital care per 1,000 members, and the average length of hospital stay was 7.53 days.

Administrative costs amounted to 66.4 cents per person covered.

Ohio's Nutrition Programs . . .

Special Activities of State and Local Health Departments Described; Pleas for Physicians To Cooperate, Especially in Educational Program

By IZOLA F. WILLIAMS, M. S.

Chief, Nutrition Service, Ohio Department of Health

THE decline in incidence of dietary deficiency diseases has resulted in a strong tendency to take for granted that we all have good nutrition and that there is no need for attention in this area. Actually, there is reason to believe that most Ohioans have fair or good nutrition, but this does not indicate that further nutrition teaching is unnecessary. In fact, there is much evidence that continuous information is needed by various age and stress groups, i. e., school children, pregnant women, families or older people on welfare, diabetics, and tuberculosis patients. Ohio attempts to provide this in a variety of ways. Agencies most active in this direction are state and local health departments, universities, agricultural departments, dairy councils, school lunch programs, and voluntary health organizations.

In this presentation an attempt will be made to describe the programs conducted by state and local health departments with the hope that physicians may give support to and take advantage of these services in their communities. In an article recently published, Dr. W. Henry Sebrell, Jr., states: "Physicians should assume a leading place in urging and educating people to appreciate the importance of good nutrition at all ages, and in teaching them how to attain it by proper eating habits. The physician can be particularly effective because he is in a position to provide the motivation necessary to effect a permanent change for the better."

Nutrition in Diabetes

In several communities the local health department, with the cooperation of physicians and with substantial assistance from state health department nutrition and nursing personnel, has taught classes for diabetic patients and members of their families. In general, the classes have included basic information on menu planning and food values, and have given some attention to problems met by individuals in following the physicians' dietary prescriptions.

This service has met a real need of diabetic patients and their physicians. The average physician is too pressed for time to obtain a diet his-

EDITOR'S NOTE:

This article was prepared at the specific request of *The Journal* in order to give Ohio physicians up-to-date and authentic information on nutrition educational activities among the citizens of Ohio. In doing so, *The Journal* hopes that all physicians will be stimulated to give their active support to programs being carried on in their respective communities or to initiate such programs where none is now in operation.

tory and give a course in basic nutrition to each new diabetic patient. The new patient, seeing a waiting room full of other patients, is reluctant to tell his physician of the dietary problems that puzzle him. However, he will usually discuss them in a group of patients with similar problems where there is a period of time devoted to discussion.

A few other counties and cities are planning to begin classes for diabetics. Physicians can speed up the development of such plans for their communities by indicating their interest to local health commissioners.

Nutrition in Tuberculosis

Although every effort is made to give the tuberculous patient an optimum diet while he is in the hospital, and physicians, nurses, and dietitians encourage him to eat the diet served to him, patients after being discharged have reverted to poor dietary patterns. In 1955, a few TB hospitals in Ohio had made substantial progress toward meeting this problem through a regular program of nutrition education for their patients; however, this was not true in all the twenty-two sanatoria scattered throughout the state.

The Ohio Department of Health employed a nutrition consultant to work especially in the areas of chronic diseases and tuberculosis. Her first efforts were devoted to a study of educational methods being used in TB hospitals having established educational programs including nutrition. The results of her observations were evaluated and with

the assistance of the Ohio TB Hospital in Columbus, a series of nutrition classes were taught to TB patients as a pilot study. From this series and from later classes taught at Oak Ridge and Franklin County TB Hospitals, lesson plans and visual materials have been developed which are now used in 14 sanatoria in the state.

In initiating the classes, the nutrition consultant assists the hospital staff in locating and training a competent teacher in the community. If practical, the hospital uses a qualified member of its own dietary staff, but often the teacher is a dietitian (or home economist with nutrition training) who lives in the community and can devote part of her time to this type of activity. In the 62 series of classes thus far held, approximately 980 patients have received basic information on what constitutes a good diet in terms of ordinary foods, how to get an adequate diet on a low income, and some knowledge of the more important food values. In most hospitals nutrition class teaching is "fortified" by information coming from physicians, nurses, and hospital aides who are in frequent contact with the patient.

In general, patients and hospital personnel have given a gratifying response to nutrition classes and many show a sustained interest in learning about nutrition in relation to health. Patients frequently suggest that information be given to their families and this is being carried out in many areas through the home visits of public health nurses. When the family physician lends his support to this program, the TB patient returning to his home has an even greater incentive to continue his efforts to eat an adequate diet.

Infectious Hepatitis

Outbreaks of infectious hepatitis have presented unusual problems in many Ohio communities during the past few years. Dietary treatment during a long convalescence, especially for school children, has seemed impractical though highly desirable. Nutritionists and nursing personnel of the Ohio Department of Health prepare local public health nurses to give assistance to mothers in following the physician's diet instructions. Also, materials are available to assist schools in supplementing the normal diet to meet the needs of children recovering from infectious hepatitis.

Weight Control

Nutrition services for groups interested in weight control, especially those interested in losing weight have been provided in many parts of the state. In Cleveland this resulted in a cooperative effort of several community agencies including the Cleveland Diabetes Association, the Cuyahoga

County and Cleveland Departments of Health. In other sections of the state it was accomplished as a joint enterprise of local health departments and Agricultural Extension workers, with assistance from their medical societies. Most active among these groups have been those established in Greene County in 1955 and somewhat later in Ashtabula County. A high percentage of participants in weight control discussion are women who are homemakers. Generally, emphasis is placed upon teaching the "would be" reducer the fundamentals of a balanced diet, something about food values, and how to plan and prepare meals that will help the individual to achieve and maintain optimum weight.

The TOPS organization (Take Off Pounds Safely) is active in several of Ohio's urban communities and has used the services of nutritionists, dietitians, and physicians whenever available. In a few communities weight control classes for young men have been sponsored by voluntary agencies and similar services for obese adolescents have been provided in a few schools.

Prevention, the best answer to the problem of obesity, is the aim of much of the nutrition teaching done in elementary and secondary schools.

At best, Ohio's program for weight control reaches only a small portion of the group needing it most, i. e., those who are just beginning to put on excess weight. Physicians see few at this point, (unless they happen to have other medical problems) and have little opportunity to do much about prevention, except through their cooperation with community nutrition programs such as those described above.

A great hindrance to the success of any sound program on weight control is the ever-increasing amount of reducing pills, appliances, and fad diets being advertised on all mass media. The old "get rich quick" schemes are being replaced in our culture by equally fallacious "get slim quick" schemes. Interest in health in relation to weight is high in Ohio's population but ways of reaching large numbers of people with sound information seem to be scarce. The physician's ideas and assistance are needed to solve this problem in his community.

Nursing Homes and Homes for Aged

It is not news to physicians that only a small percentage of the approximately 900 nursing and rest homes in Ohio employ dietitians. (Indeed, with the present shortage of dietitians almost 100 of our smaller hospitals have been unable to hire a dietitian.) Under these circumstances it is little wonder that therapeutic diets are a source of much

difficulty to the physician, his patients, and nursing home personnel. To partially meet this problem nutrition personnel of the Ohio Department of Health and the Ohio Dietetic Association, with advice from members of allied professional groups, developed the Ohio Diet Manual for use in nursing homes and small hospitals not having trained dietary personnel. The Manual gives normal diets and suggested menu patterns for various age groups. Using the same menus the writers show how each of the usual types of dietary modification may be made. The purpose and basic principles of each type of modification are given in non-technical language.

Nutritionists of the Ohio Department of Health, working with the nursing consultants of the Ohio Department of Welfare (the state licensing agency for nursing homes) have held 14 meetings during the past year to explain the use of the Ohio Diet Manual to nursing home operators and their food service managers. Thus far, copies of the Manual have been placed in more than 150 nursing homes. In addition, many hospitals have obtained copies. **Physicians who would like a copy of the Diet Manual may obtain one** by writing to: Nutrition Chief, Ohio Department of Health, Columbus. A physician who has his own office copy will find it a time-saver in giving dietary instructions by telephone to nursing home operators using the Manual.

In three of Ohio's larger cities consultation is being provided for most nursing homes and rest homes by local nutritionists. In Cincinnati and in Dayton it is given by a nutritionist employed by the City Health Department and in Cleveland by a dietary consultant employed by the Welfare Federation. In Toledo a program of in-service training including nutrition is being conducted for nursing home personnel by the Toledo Health Department, utilizing the part-time services of a nutritionist provided by the Ohio Department of Health. Later it is expected that Toledo will be able to add a full-time nutritionist to the health department staff. Columbus began the licensure of nursing and rest homes in January 1959. It is not known whether the licensure procedure will include the provision of dietary consultation, since the Columbus City Health Department, the licensing agency, employs no nutrition or dietary personnel.

Hospitals Without Dietitians

It is known that more than one hundred hospitals in Ohio operate without the services of a trained dietitian. Most of these are small institutions with a capacity of less than 75 beds. A standing committee of the Ohio Dietetic Associa-

tion has assisted a few of these hospitals in locating trained dietitians to work on a part-time or "shared" basis. If this small beginning can be developed and expanded it should do much toward meeting the problem. It is believed that the distribution and use of the Ohio Diet Manual described under the Nursing Home Section can give valuable assistance to this group of hospitals in providing therapeutic diets.

Another service designed to aid this group is that rendered by a dietary consultant employed by the Ohio Department of Health. Upon request, a consultation visit of from one to three days is made to study the operation of a hospital's dietary department and then recommendations for improvement of the service are made. Usually, these visits deal principally with problems of dietary administration such as menu planning, food purchasing, storage, scheduling, and service to patients, but often the service has included teaching demonstrations of such details of food preparation as the use of a vegetable steamer which had stood idle for months, because kitchen personnel were afraid of it, or how to make good coffee.

The dietary consultant also assists hospitals and larger nursing homes and children's homes in planning layout and equipment for new or remodeled kitchens. Occasionally a consultant participates in the opening of a new hospital dietary department and works a few days with kitchen personnel to help achieve a smooth operation.

Unfortunately, many eligible hospitals have not taken advantage of the services described due to the lack of information regarding the availability of this help. Physicians meeting frequent difficulties with respect to therapeutic diets may wish to promote action toward the use of these services by the small hospital's dietary department.

Children's Homes

During the past ten years approximately 150 licensed children's homes in the state have been visited annually by a nutritionist to evaluate the food service in terms of nutritional adequacy. During the visit, the nutritionist usually observes the preparation and serving of at least one meal, goes over menus of meals served for at least one week, examines storerooms, purchase orders, etc. However, the visit is a "consultation" rather than an "inspection" and usually is so regarded by all concerned. The superintendent, matron, cook and other personnel usually hold a conference session with the nutritionist for a discussion of her recommendations. Later, the nutritionist submits a written report of her findings and recom-

mentations which are passed on to the licensing agency for follow-up.

There is a very large group, more than 4000 in number, of non-licensed, small, (usually fewer than 10 children) boarding homes for children in the state which provide care for approximately 25,000 children. Very little nutrition service has been provided directly for this group. However, through nutrition services to the local health and welfare workers who visit these homes some assistance is being provided with problems of feeding.

Crippled Children

Services for crippled children are provided on different bases in different parts of the state. In the large southeastern area they are provided through itinerant clinics held in the fall and spring months. From time to time, as need indicates, many of these clinics are provided with a nutrition consultant to discuss special feeding problems with the child's parents. If the public health nurse who visits the family cannot participate in the discussion, notes for follow-up are given to her by the nutritionist later. Many of these children have very good nutrition, but a substantial group are troubled by problems of over-weight, and coupled with an orthopedic handicap, this usually presents a major difficulty. Nutrition services are needed and appreciated in these circumstances.

Infant, Pre-School and Maternal Nutrition

Many local health departments and other agencies sponsor well-child conferences for low income areas of the larger cities or rural areas where the need is great and physicians in short supply. In Dayton, these conferences are served regularly by a nutritionist, but in other areas consultation on special feeding problems is provided by a physician. Public health nurses serving in these conferences, with teaching materials and in-service training from district nutrition consultants, give mothers assistance with normal diets for infants and pre-school children.

Most information on the pre-natal diet is given by physicians. In some cities, hospitals or health departments supplement physicians' advice at their request with general information on diet in pregnancy given in a series of parent's classes. The Division of Nursing of the Ohio Department of Health, with assistance from allied personnel including a nutritionist, has prepared a manual and suggested lesson plans for such classes.

Public health nurses, in their regular home visits, advise mothers in regard to family nutrition. This help is especially effective for families on welfare (or with similarly low income) and

those in the moderate income group with health problems that make heavy demands on the family budget.

Nutrition in Schools

A high percentage of public and parochial schools have a lunch program through which children are given an opportunity to obtain a balanced lunch providing at least one-third of the day's food requirements. In most of these schools this program receives federal financial support and administrative and supervisory services through the Division of Public School Lunch of the Ohio Department of Education. Although the maintenance of good nutrition for the school child is a main objective of the lunch program, it offers, also, an opportunity to help the child establish good food habits and often serves as a "laboratory" for classroom nutrition teaching.

Elementary teachers usually teach nutrition as part of health at each grade level. In junior and senior high schools it is taught as part of health and physical education and as a part of science courses. Unfortunately, the extent and effectiveness of nutrition teaching varies tremendously from one school system to another and, of course, with the interest and preparation of individual teachers. To help overcome this handicap in our system we have many public health nurses, school nurses, and dairy council nutritionists prepared to assist teachers in developing suitable classroom projects and in obtaining visual aids to teach nutrition. In addition to her basic training which includes nutrition, the public health or school nurse usually has available the consultative services of a District Nutritionist employed by the Ohio Department of Health. When several teachers or entire schools are involved, the Nutrition Consultant often is called on to assist in setting up surveys to determine specific areas of need in nutrition teaching and to provide in-service training for nurses and teachers.

High school athletic coaches have a strong interest in nutrition and its immediate effects on physical performance. They are in an unusually good position to motivate high school boys toward improved food habits, but unfortunately few have had sufficient training in nutrition and growth and development to do an effective job. This group needs more assistance from physicians and nutritionists.

Education for General Public

World War II focused much public interest on nutrition which has decreased but little during the past decade. A quick glance into almost any popular magazine reveals a "special" diet to lose weight, to prevent heart trouble, or to regain

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lost youth. People are interested in nutrition and if not directed by professionals with sound nutrition training often fall under the influence of the food faddist or nutrition quack. Agencies employing nutritionists and dietitians are devoting an increasing amount of attention to television and radio programs and literature designed to keep the public informed. The American Medical Association is now engaged in a new program designed to counteract directly the influence of the "modern medicine man." It is hoped that local medical societies will use this opportunity to help their communities increase resistance to the door-to-door vitamin pill salesmen, the health lecturer, and the health food stores providing "nutrition consultation" by persons with no training.

Physicians' Help Needed

Professional personnel with basic training for understanding and applying nutrition research are scarce. The success of nutrition programs of a state are directly dependent upon the active cooperation of all who have such training. Physicians graduate with an excellent foundation in nutrition, but finding it difficult to keep up to date in all phases of medicine many neglect to read journals or attend seminars dealing with the subject. Consequently, they give attention to diet only when it appears as a major problem in a patient. Normal nutrition, although basic to good health, is discussed with the patient much less often than immunizations, drugs, or exercise. Far reaching results might be obtained if physicians were to begin giving as much attention to the patient's long term dietary habits as to his aches and pains.

Physicians singly, or in groups can do much to promote the success of a community's nutrition programs; first, by learning what is being done and who is doing it; second, by lending a helping hand through exhibits, talks, and conferences; and third, by sponsoring and participating in seminars and institutes on nutrition.

Western Reserve Receives Grants From National Foundation

Western Reserve University, Cleveland, received two grants among those recently announced by the National Foundation. A three-year grant of \$157,464 was recommended for the Western Reserve University School of Medicine as a continuation support for "conducting pilot studies in teaching the concept and basic techniques of rehabilitation to undergraduate and graduate medical students." A four-year grant of \$89,976 was made to the University to establish a 2-year curriculum in physical therapy in the graduate school.

Assignment Statement Made A Part of OMI Claim Form

A REVISED CLAIM FORM has been instituted by Ohio Medical Indemnity, Inc., carrying a claim payment authorization.

The wording of the assignment which the attending physician, if he desires, request a patient to sign, is as follows:

"I authorize Ohio Medical Indemnity, Inc., to issue indemnity check(s) jointly to Subscriber and the physician(s) rendering the services described on this claim form."

This action by the Board of Directors of OMI was in response to many requests from physicians asking that an assignment statement be made a part of the regular OMI claim form.

Insurance Institute Promotes Heart Research Projects in Ohio

A total of \$1,205,510 has been allocated this year for heart research by the Life Insurance Medical Research Fund, it was announced by Dr. Francis R. Dieuaide, scientific director of the fund.

There are 83 awards in all. Sixty-four are to medical research institutions in 22 states (four in Ohio), the District of Columbia, four Canadian provinces and Mexico.

The Life Insurance Medical Research Fund, organized in 1945, receives its support from a group of about 140 life insurance companies in the United States and Canada. Its resources are devoted entirely to fighting the No. 1 cause of death—heart disease. Each year more than one million dollars has been allocated to this cause.

Grants in Ohio include the following:

Cleveland Clinic Foundation, for research by Dr. Harriet P. Dustan on participation of angiotensin in renal hypertension, \$13,530.

Ohio State University Research Foundation, Columbus, for research by Dr. Francis W. McCoy on the juxtaglomerular apparatus of the kidney, \$5,280.

St. Luke's Hospital, Cleveland, for research by Dr. Frederick S. Cross on techniques for open repair of acquired mitral and aortic lesions, \$16,500.

University of Cincinnati College of Medicine, for research by Dr. William D. Lotspeich on the biological transport of sugars, \$33,000.

U. S. Circuit Court of Appeals in San Francisco has ruled that Carter Products, Inc., must quit using the word "liver" in promoting its bills. The company plans to appeal.

If one . . . or all . . . needs nutritional support . . .



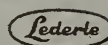
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Eleven Conferences . . .

Being Sponsored by OSMA in Councilor Districts This Fall for County Society Officials and Representatives of Press, Radio and Television

ELEVEN district conferences will be held this Fall under the sponsorship of the Ohio State Medical Association. They will be invitational affairs for presidents, presidents-elect, secretary-treasurers, chairmen of public relations committees and executive secretaries of the County Medical Societies; Councilors and officers of the State Association; and as dinner guests, representatives of the daily newspapers and the radio and television stations of the various Councilor Districts.

Start at 4 P. M.

The conferences will begin at 4:00 P. M. Following a social hour at 6:00 P. M. and dinner at 6:30 P. M. there will be informal discussions of the relationship between medical societies and individual physicians and the various media of communications.

The afternoon part of each conference will be devoted to discussions of activities of the OSMA, current social-economic-legislative issues, and public relations questions. Also, there will be opportunities for officials of the various County Medical Societies to bring up questions on which they would like to have information or advice from State Association officials.

Letters of invitation have been sent to representatives of the County Medical Societies and of the daily newspapers and radio and television stations of the state.

Dates and Places

The dates and places for the 11 conferences are as follows:

September 23, Second District, Van Cleve Hotel, Dayton

September 24, Fourth District, Toledo Academy of Medicine Headquarters, Toledo

September 30, Tenth District, Lincoln Lodge, Columbus

October 1, First District, University Club, Cincinnati

October 13, Seventh District, Reeves Hotel, New Philadelphia

October 14, Fifth District, Wade Park Manor, Cleveland

October 29, Third District, Shawnee Country Club, Lima

November 3, Eleventh District, Ashland Country Club, Ashland

November 4, Sixth District, Congress Lake Country Club, near Canton

November 5, Eighth District, Zanesville Country Club, Zanesville

November 12, Ninth District, Lake White Club, Lake White near Waverly

Dr. Mayfield's Idea

These meetings at which representatives of the press, radio and television will be guests and asked to participate in informal discussions and question-answer exchanges, were arranged on recommendation of Dr. Frank H. Mayfield, President of the State Association, and with the unanimous approval of The Council.

In his address before the House of Delegates at this year's Annual Meeting at the time he took over the presidency of the Association, Dr. Mayfield said:

"We must, of course, continue to search for and correct shortcomings and abuses in our system; and accept as constructive criticism inadequacies that are pointed out to us by others. But we must also acquaint the public with the true story.

Need Understanding

"In order to tell the story adequately, I think it is necessary to establish better relations between the local press and every county society in this state. My concept of the proper methods in this field are neither new nor original. Simply stated, its object is to get the people who make medical news to know and understand the people who write the news. I consider it appropriate and will ask the Council to authorize the use of this society as the instrument for bringing about a closer relationship between all the media of communications which I shall describe collectively as the press."

Cincinnati Program

After describing in detail a program developed in Cincinnati which has produced an effective

working relationship between the Cincinnati Academy of Medicine and the press, radio and television representatives in that area, Dr. Mayfield offered the assistance of the State Association to the County Medical Societies on such matters and suggested that district conferences be held.

"My thoughts are that many of the societies may need help in promoting such programs," said Dr. Mayfield, "and I envisage public relations seminars in each councilor district during the coming year. But by seminars I do not visualize a didactic program but instead use the word in its true sense, namely, that of a "seed plot" or a class of students engaged in original research or other specialized study.

Offers Assistance

"It is my thought that the people who tell the news should be on this occasion the guests of those who make the news and join in a candid and friendly discussion of their objectives and differences.

"If I am authorized to proceed, it is unlikely that a full schedule of meetings could be completed before the Fall, but when I accepted the responsibility of this office, I assured you that I would be at your service. I mean to abide by that

promise. And if any district or county society wants to get going soon and would wish the help of the President, the Councilors or our administrative staff, or even perhaps outside professional help, we will be ready when you are.

Benefit to All

"I know if a closer relationship with the press is established, that immeasurable benefit will accrue to the public and hence, also to the profession.

"The first step is to engender a new and friendly understanding with the media that confer with the public every day. I am convinced that they want to tell the truth and the truth is good enough for me.

"I also know from past experience that if they are unable to find the whole truth that they will tell what they believe to be the truth. It is incumbent upon us, therefore, to insure that they know the truth.

"Once the lines of communication are open, the rest should be easy. We know if the public understands our ideals, recognizes the integrity of our standards, shares our intensity of purpose, we need have no fear for the future of the profession for which we have dedicated our lives."

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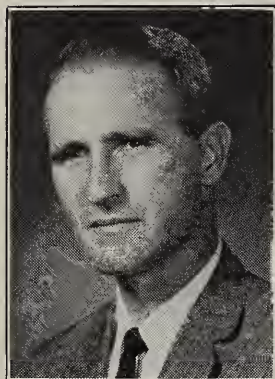
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Assistant Executive Secretary Is Named by Cincinnati Academy

Appointment of W. Eugene Little, of Morrow, Ohio, as assistant executive secretary of the Academy of Medicine of Cincinnati has been announced by D. J. Robert Hudson, president. Mr. Little



Eugene Little

will assist Edward F. Willenborg, executive secretary, with certain phases of the work connected with administering the Academy and its associated services.

An army veteran of World War II, Mr. Little has been associated with the Auto-Lite Company in the employment and personnel department. He handled labor rela-

tions, insurance, safety, employee benefits, hiring, remedial transfers, complaints and grievances, ratings and promotions.

Mr. Little has served in the Merchant Marine for two years, spent a year at Okinawa University and two years at the National Coaching Institute. He is married and has three children.

Heart Program Scheduled in Defiance, September 23

Earle B. Kay, M. D., chief of thoracic and cardiovascular surgery at St. Vincent Charity Hospital, Cleveland, will address a meeting of physicians from seven Northwestern Ohio counties Thursday, September 23, 1959, at 8 P. M. at the Defiance Hospital, Defiance. Dr. Kay will speak on open heart surgery. The meeting is being sponsored by the Defiance County Heart Association and the Western Ohio Heart Chapter.

Chest Physicians Announce Three District Programs

The American College of Chest Physicians will present the following postgraduate courses this fall:

Fourteenth course, Clinical Cardiopulmonary Physiology, Edgewater Beach Hotel, Chicago, October 5-9.

Twelfth annual course on Diseases of the Chest, Park Sheraton Hotel, New York City, November 9-13.

Fifth annual course on Diseases of the Chest, Ambassador Hotel, Los Angeles, December 7-11.

Ohioans Take Part in District Program of Obstetricians and Gynecologists

Several Ohio physicians are scheduled to participate in the program of District V of the American College of Obstetricians and Gynecologists, when that group meets in the Statler Hilton Hotel, Detroit, Mich., November 18-21.

Dr. John C. Ullery, Columbus, is co-author of a paper to be presented entitled, "Once a Caesarean Section Always a Caesarean?—and Other Unnecessary Caesarean Sections."

Dr. Arthur R. Fleming, Gallipolis, is scheduled to speak on "Complete Perineotomy."

Dr. Zeph J. R. Hollenbeck, Columbus, will speak on "Injuries to Ureter, Bladder and Bowel in Gynecologic Surgery."

Drs. John R. Holzaepfel and Harry E. Ezell, Columbus, are co-authors of a paper to be presented on "Radiation Complications Following Treatment for Pelvic Carcinoma."

Dr. Charles H. Hendricks, Cleveland, will speak on "Control of Uterine Activity."

Dr. Arthur G. King, 199 William Howard Taft Road, Cincinnati 19, is District V chairman. Dr. Hollenbeck and Dr. Holzaepfel are chairman and vice-chairman, respectively, of the Ohio section.



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Out of the Blue . . .

Another Article of Interest to OSMA Members Regarding Ohio's Blue Shield Plan Prepared by Dr. R. D. Dooley, OMI Physicians' Relations Director

By R. DEAN DOOLEY, M.D.

Director, Physicians' Relations Department, Ohio Medical Indemnity,
3770 N. High St., Columbus 14, Ohio

SOME PHYSICIANS have been heard to express the opinion that the Ohio Medical Indemnity is failing at times to meet subscribers' needs. It may be interesting to peek behind the curtains to see just how a contract is written. The indemnity benefits and the premium rates are not recklessly pulled out of the air, but are calculated after long studies, abundant consultations and resort to a tremendous store of experience gained through the years.

First, a knowledge of physicians' charges in all the categories of medicine must be had before an effective contract can be written. Being a doctor's plan, we have access to the best source of information and we make broad use of advice gained first-hand from physicians engaged in supplying the services to subscribers for which we are attempting to make reasonable payment.

Pioneering Work

Many Ohio physicians gave tremendous amounts of time in the early days of O. M. I. in helping devise an indemnity schedule to satisfactorily serve our subscribers. The recorded minutes reveal the dedication and sacrifice of the pioneers who sponsored and nurtured O. M. I. That it has grown and has served millions of Ohioans and gives the bright promise of continued service is a monument to the wisdom of these gentlemen to whom the physicians and the people of Ohio are so deeply indebted.

We continue to lean heavily on the sturdy shoulders of medical stalwarts who are on the firing line contributing their utmost to the cause of American medicine. In the development of the new Major Contract, specialty groups and other physicians from all sections of the state came at our request to advise us on the technical aspects of the new contract.

Actually, the physicians themselves are the architects of the OMI structure, and the administrative staff has directed its efforts to build in strict accordance to the blueprints of the designers. You may be sure the changes suggested to correct struc-

tural weaknesses, which you the architects may discover, will be given very serious consideration.

It Is the Doctor's Plan

Why is it called the Doctor's Plan? It indeed is the Doctor's Plan—designed, controlled, regulated and owned by the physicians of Ohio. We, Ohio physicians, should be as interested in the successful operation of our insurance plan as we are in the affairs of our own practices. Our OMI, a member of the prepayment budgeting team, is our last resort in the preservation of our cherished medical traditions, and deserves our undivided support, not only for the rewards which will be returned to us, but for the legacy we shall leave to posterity.

* * *

We are often asked the question, "Why can't OMI offer at all times a contract to non-group, across-the-counter applicants and why is it necessary to reduce the benefits and increase the premium rates in this category of subscribers?"

The insurance industry is affected by rules just as binding as formulas in mathematics. To ignore these basic principles is just as risky to an insurance company as a failure by an automobile driver to observe the warning of the blinker lights at a railroad crossing.

Dangerous Procedure

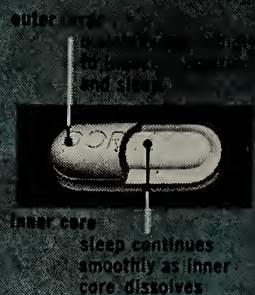
It must be apparent to everyone that an open enrollment in Blue Shield offers the opportunity for individuals facing elective surgery or the chronically ill to obtain protection against certain expenses confronting them. A well person will less likely be attracted by the offer. Consequently, in the non-group classification we have a higher percentage of subscribers utilizing the benefits of their contracts.

The reasoning behind the requirement of a high percentage of employees in group enrollment is that there must be a spread of risks if desirable benefits are to be offered at favorable premium rates. Here again, if the percentage requirement is not imposed, the unhealthy employee could not

(Continued on Page 1278)

For those patients who complain

carries your patients through the middle of the night



Each Nebralin timed-release tablet contains:

Dorsital* 90 mg

Warning: May be habit forming

Mephenesin 425 mg

*Dorsey brand of pentobarbital

CAUTION: Federal law prohibits dispensing without prescription

Dosage: One or two tablets ½ hour before retiring.

about waking up at 2 A.M.



nebralin

timed-release tablet

timed-release action for a full night's sleep

NEBRALIN is designed to duplicate the normal sleep pattern. It encourages muscular relaxation and induces sustained, relaxed sleep by the release of Dorsital and mephesisin in a timed-release tablet. Rapid-acting mephesisin quickly relaxes skeletal muscles to overcome "fatigue-tension" and conditions the body for sleep. Dorsital provides CNS sedation to induce sound, relaxed sleep. The initial and sustaining dosages are designed to keep the amount of barbiturate to be inactivated at any one time at a low level tapering toward morning. Evidence indicates that mephesisin is capable of producing sleep,¹ and when combined with a barbiturate enhances barbiturate action.²⁻⁴ Moreover, the integrated action of the two components permits smaller dosages of each,⁴ assuring your patients refreshed awakenings without "morning hangover."

¹ Schlesinger, E. B.: Tr. New York Acad. Sc. 2:6, (Nov.) 1948.

² Richards, R. K., and Taylor, J. D.: Anesthesiology 17:414, 1956.

³ Shideman, F. E.: Postgrad. Med. 24:207, 1958.

⁴ Berger, F.: Pharmacol. Rev. 1:243, 1949.

afford to gamble with almost certain expense of illness and would enroll; whereas the good health risk would take a chance since the imminence of the need of coverage is not immediately apparent to him. For example, it would be far better from an insurance standpoint to have a hundred per cent enrollment from a group of 100 than to have 100 subscribers enrolled equally from ten groups of 100 each.

Premiums are calculated on the premise that there will be a reasonably sizeable percentage of people covered who will not have need of their insurance benefits, and when the percentage of those who use their coverage gets out of balance, the insurance company is in financial trouble.

Heart Association To Be Publisher Of Its Scientific Journals

The American Heart Association will begin direct publication of its two scientific journals, *Circulation* and *Circulation Research*, with the January 1960 number. The announcement was made by Dr. J. Scott Butterworth, chairman of the AHA's Publications Committee.

Under the new arrangement, business communications for *Circulation* and *Circulation on Research* may be addressed to the Publishing Director's office at the American Heart Association, 44 East 23rd Street, New York 10, N. Y.

As in the past, editorial communications for *Circulation* will be received by Dr. Herrman L. Blumgart, 330 Brookline Avenue, Boston, and, for *Circulation Research*, by Dr. Carl F. Schmidt, Laboratory of Pharmacology, University of Pennsylvania School of Medicine, Philadelphia 4, Pa.

Also published by the American Heart Association is *Modern Concepts of Cardiovascular Disease*, a monthly bulletin devoted to some single aspect of cardiovascular medicine. In addition, the Association sponsors *The Heart Bulletin* in cooperation with the National Heart Institute and the American Academy of General Practice.

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Ohioan Named President-Elect of Physicians' Art Association

An Ohioan was named president-elect of the American Physicians Art Association and five other state doctors exhibited their work at the national convention. The 22nd annual APAA exhibit was held in Atlantic City during the American Medical Association Session there. More than 200 paintings, sculptures, photographs and crafts were on exhibit.

Dr. Thomas A. Newell, Dayton, was named president-elect of the group. The following Ohio physicians were among exhibitors: Dr. A. S. Burton, Newark, color photographs; Dr. Sidney Dinkin, Dayton, water colors; Dr. Louisa Kerschbaumer, Youngstown, oils; Dr. Richard M. Murray, Youngstown, oils; Dr. Newell, drawings and water colors.

The exhibition received nationwide publicity and drew thousands of visitors. President Dwight D. Eisenhower, an artist in his own right and his personal physician, Dr. Howard Snyder, were made honorary members of the APAA on the occasion of their visit to the AMA Convention.

Further information on the APAA may be obtained by writing Dr. Newell, at 854 N. Broadway, Dayton 7, Ohio.

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In Memoriam . . .

William W. Alderdyce, M. D., Toledo; Toledo Medical College, 1900; aged 87; died July 3; former member of the Ohio State Medical Association and the American Medical Association; member of the American Academy of Ophthalmology and Otolaryngology; Fellow of the American College of Surgeons. Dr. Alderdyce served most of his professional career in Toledo and in 1950 was presented the OSMA 50-Year Award. He was treasurer of the Academy of Medicine of Toledo for 33 years, and formerly served the local society as president, secretary and as member and chairman of the board. Affiliations included memberships in the Rotary Club and several Masonic bodies. Surviving are his widow, a son and two sisters.

Charles Baker, M. D., West Milton; Medical College of Ohio, Cincinnati, 1899; aged 86; died July 26; member of the Ohio State Medical Association and the American Medical Association. A native of Darke County, Dr. Baker practiced in that county at Stelvideo for several years before he moved to West Milton in 1914, where he continued in practice until his retirement in 1943. He participated in many local activities; was a member of the Chamber of Commerce, the Congregational Christian Church, and several Masonic bodies. Surviving are his widow, a daughter, a son, Dr. Lynne Baker of Dayton, and three sisters.

Robert P. Bausch, M. D., Columbus; Ohio State University College of Medicine, 1916; aged 66; died July 17; former member of the Ohio State Medical Association. A veteran of World War I, during which he served with the Army Medical Corps, Dr. Bausch practiced for many years in Columbus. He was a member of the VFW and the Masonic Lodge. A sister and two brothers survive.

Oscar Berghausen, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1904; aged 80; died July 27; member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Internal Medicine. Dr. Berghausen served the greater part of his professional career in Cincinnati, having gone to Europe early for residency training. He is survived by his widow, a daughter, two sons, two sisters and a brother.

Carl G. Braunlin, M. D., Portsmouth; Miami Medical College, Cincinnati, 1909; aged 75; died July 9; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. A native

of Portsmouth, Dr. Braunlin returned there to practice in 1913 after engaging in government services. This year he completed 50 years of service in the medical profession. Active in a number of local advancement projects, he helped organize Portsmouth General Hospital. Surviving are his widow and three physician daughters, all of Portsmouth—Dr. Ruth Bennett, Dr. Marie Rogowski and Dr. Janet Hugenberg; also a sister and four physician brothers—Dr. Walter Braunlin of Portsmouth; Dr. William Braunlin and Dr. Robert Braunlin, both of Marion, Ind., and Dr. Edgar L. Braunlin, of Dayton.

Harry Guy Brown, M. D., Cincinnati; Eclectic Medical College, Cincinnati, 1921; aged 64; died July 20; member of the Ohio State Medical Association and the American Medical Association. Recently examiner for the Bureau of Workmen's Compensation in the Cincinnati area, Dr. Brown previously was in private practice for about 30 years. A veteran of World War I, he was a member of the American Legion; also a member of several Masonic bodies and the Presbyterian Church. Surviving are his widow and a son, Dr. John Brown of Dayton.

Charles E. Burgett, M. D., Dayton; Kentucky School of Medicine, 1898; aged 93; died July 24; former member of the Ohio State Medical Association. Dr. Burgett practiced over a period of 61 years and was still seeing patients just before his death. Formerly in Melrose for some 25 years, he moved to Dayton 36 years ago. A member of several Masonic bodies and the Evangelical United Brethren Church, he is survived by a nephew.

Herbert D. Chamberlain, M. D., McArthur; Ohio State University College of Medicine, 1933; aged 60; died August 10; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Chamberlain practiced since the early 1930's in the area of McArthur and for many years was the only doctor in Vinton County. In recent years he and Dr. Richard E. Bullock took turns as president and secretary of the Vinton County Medical Society. Dr. Chamberlain received national recognition a few years ago when he reported on his local procedure of immunizing newborn babies. He was active on the OSMA Committee on Maternal Health and for many years was a member of the House of Delegates of the State Association. A veteran of World War I, during

(Continued on Page 1282)

avoid the risk of insoluble, irritating aspirin particles

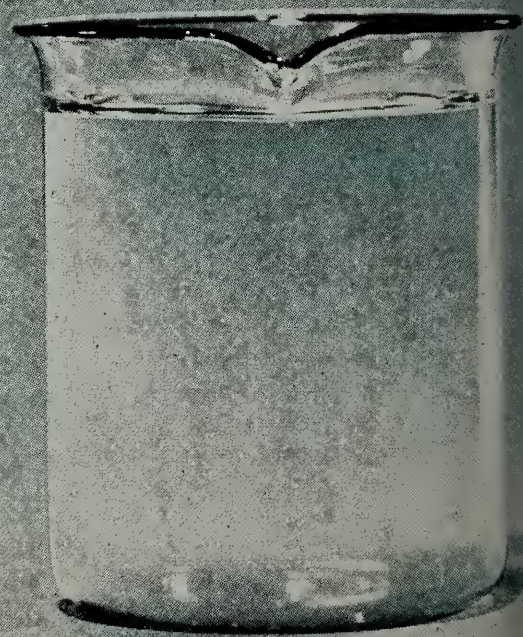
Chief among the drawbacks to aspirin usage is gastric intolerance. This ranges from mild upset and "heartburn" to severe hemorrhagic gastritis.¹⁻¹⁰ Studies performed in conjunction with gastrectomy^{4, 5} and gastroscopy² have shown insoluble aspirin particles firmly adherent to

the gastric mucosa and imbedded between rugae. Reactions varying from mild hyperemia to erosive gastritis have been reported to occur in the areas immediately surrounding these adherent particles.^{2, 4, 5} This is reported to be particularly true in patients with peptic ulcer.⁴

CALURIN is the freely soluble, stable calcium aspirin complex. Its high solubility forestalls gastric irritation or damage



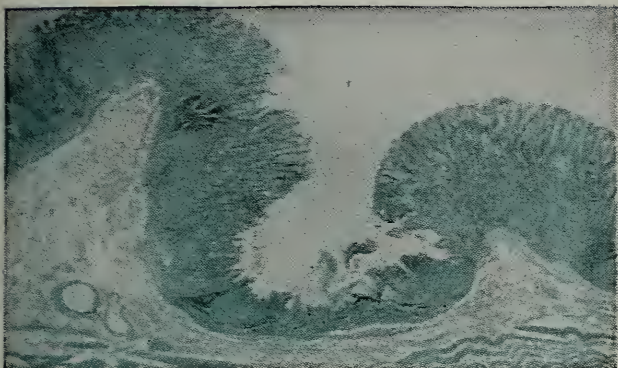
Regular aspirin crystals 24 hours after being mixed into water.



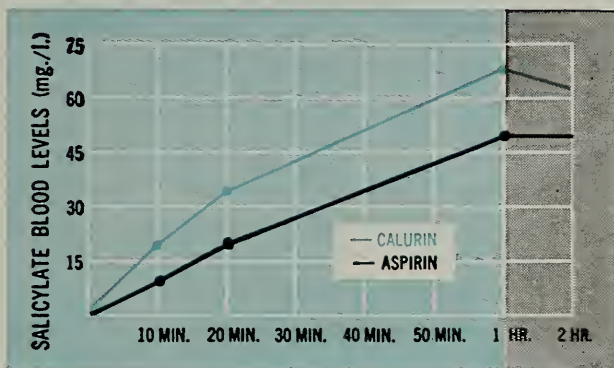
Calurin crystals in solution one minute after being mixed into water.

CALURIN*

STABLE SOLUBLE CALCIUM-ACETYLSALICYLATE-CARBAMIDE



Particle-induced ulceration — section through lesion found in gastrectomy specimen. An aspirin particle was found firmly imbedded in this undermined erosion. Such lesions may be associated with the relative insolubility of aspirin, which remains in particulate form after dispersion in gastric contents.



Calurin, being freely soluble, is promptly available for absorption into the systemic circulation. Salicylate blood levels in 12 subjects receiving both Calurin and plain aspirin were found to rise more than twice as high within ten minutes following Calurin. Also, these levels persisted higher for at least two hours.¹¹

CALURIN is the aspirin of choice, especially when high-dosage, long-term therapy is indicated:

- 1 High solubility forestalls gastric irritation or damage. This advantage is of special importance in arthritis and other conditions requiring high-dosage, long-term therapy.
- 2 Produces high salicylate blood levels rapidly for prompt analgesic, anti-pyretic, anti-arthritic effect.
- 3 Sodium-free — for safer long-term therapy.
- 4 Flavored: can be chewed or dissolved in the mouth without water if desired — an advantage for patients requiring aspirin administration during the night and for pediatric patients.

Dosage: Each tablet of Calurin is equivalent to 300 mg. (5 gr.) of acetylsalicylic acid. For relief of pain and fever in adult patients, the usual dose of Calurin is 1 to 3 tablets every 4 hours, as needed; in arthritic states, 2 or 3 tablets 3 or 4 times daily; in rheumatic

fever, 3 to 5 tablets 4 or 5 times daily. For children over 6 years, the usual dose is 1 tablet every 4 hours; for children 3 to 6 years, ½ tablet every 4 hours, as required. Not recommended for children under 3.

REFERENCES: 1. Waterson, A. P.: Aspirin and gastric haemorrhage, *Brit. M. J.* 2:1531, 1955. 2. Douthwaite, A. H., and Lintott, G. A. M.: Gastroscopic observation of the effect of aspirin and certain other substances on the stomach, *Lancet* 2:1222, 1938. 3. Editorial Comments: The effect of acetylsalicylic acid (aspirin) on the gastric mucosa, *Canad. M. A. J.* 80:47, 1959. 4. Muir, A., and Cossar, I. A.: Aspirin and ulcer, *Brit. M. J.* 2:7, 1955. 5. Muir, A., and Cossar, I. A.: Aspirin and gastric haemorrhage, *Lancet* 1:539, 1959. 6. Schneider, E. M.: Aspirin as a gastric irritant, *Gastroenterology* 33:616, 1957. 7. Bayles, T. B., and Tenckhoff, H.: Salicylate therapy in rheumatic diseases, Scientific Exhibit, Ann. Mtg. A. M. A., San Francisco, Calif., June, 1958. 8. Batterman, R. C.: Comparison of buffered and unbuffered acetylsalicylic acid, *New Eng. J. M.* 258:213, 1958. 9. Cronk, G. A.: Laboratory and clinical studies with buffered and nonbuffered acetylsalicylic acid, *New Eng. J. M.* 258:219, 1958. 10. Editorial: Aspirin plain and buffered, *Brit. M. J.* 1:349, 1959. 11. Smith, P. K.: Plasma concentration of salicylate after the administration of acetylsalicylic acid or calcium acetylsalicylate to human subjects, Report submitted to Smith-Dorsey from Dept. of Pharmacology, Geo. Washington Univ. School of Medicine, Washington, D. C., Sept. 5, 1958.

*TRADEMARK

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska

which he served in the Navy, Dr. Chamberlain was a member of several Masonic bodies. Surviving are his widow, a son, three daughters and a brother.

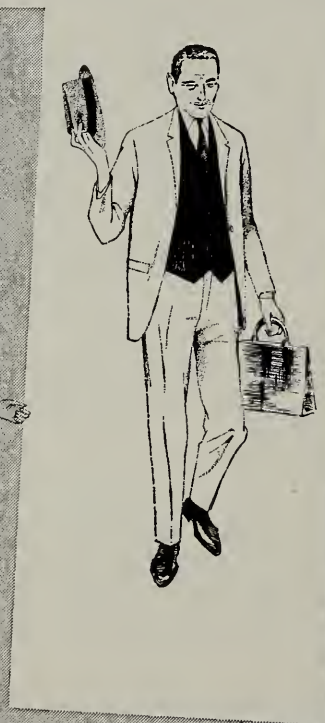
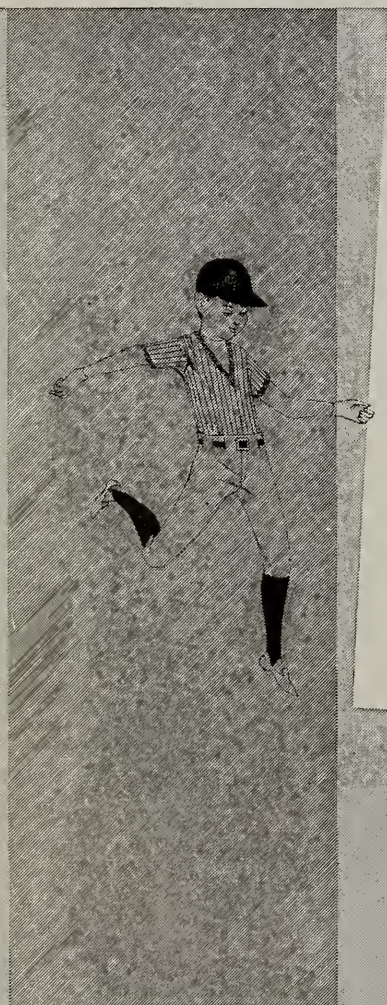
Herman C. Clayton, M. D., Sidney; Chicago College of Medicine and Surgery, 1917; aged 64; died July 29; member of the Ohio State Medical Association and the American Medical Association. Dr. Clayton practiced for about 40 years in Shelby County. Following military service during World War I, he began practice in Jackson Center and in 1925 moved to Sidney. Active in a number of organizations, he was a past-president of the Ohio Brown Swiss Cattle Breeders Association, a member of several Masonic bodies, the Rotary Club, Elks Lodge and the Presbyterian Church. Surviving are his widow, a daughter, a brother and a sister.

Ora Otis Fordyce, M. D., Coral Gables, Fla.; Ohio Medical University, Columbus, 1905; aged 84; died July 21; former member of the Ohio State Medical Association; member of the American Psychiatric Association. Dr. Fordyce was for 27 years superintendent of the Toledo State Hospi-

tal, retiring from that position in 1946. After retiring he lived in Lakeside and in Coral Gables. Survivors include his widow and two sisters.

Emil Friedlander, M. D., Cincinnati; Faculty of Medicine, University of Rostock, Germany, 1918; aged 68; died July 8; member of the Ohio State Medical Association, the American Medical Association and the American Academy of Dermatology and Syphilology. A native of Germany, Dr. Friedlander came to this country in 1939. A practicing physician in Cincinnati, he also was on the faculty of the University of Cincinnati College of Medicine. Survivors include his widow, a son and a daughter.

John C. Henshaw, Warren; Pulte Medical College, Cincinnati, 1896; aged 85; died July 23; member of the Ohio State Medical Association and the American Medical Association. Dr. Henshaw served virtually all of his professional career in Trumbull County and was a recipient of the OSMA 50-Year Award. For about 35 years also he was county coroner. He was a member of the Presbyterian Church and was associated with sev-



more
diabetic
patients
enjoy
comfort,
convenience,
better
regulation
with
effective



DBI

the only "full-range" oral hypoglycemic agent

eral lodges. Survivors include two sons and a sister.

E. Scott Hill, M. D., New York City; University of Nebraska College of Medicine, 1932; aged 52; died July 3; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons; diplomate of the American Board of Surgery. A former practitioner in Canton for many years, Dr. Hill moved to New York in 1957. His widow and children survive.

Charles B. Horton, M. D., New York City; University of Toronto Faculty of Medicine, 1925; aged 60; died July 17; member of the American Psychiatric Association. Dr. Horton was director of the Dayton Guidance Center from 1935 to 1942.

Ellis D. Kackley, M. D., Beaumont, Texas; Ohio State University College of Medicine, 1911; aged 76; died July 1; member of the Ohio State Medical Association and the American Medical Association. A native of Pleasant City, Dr. Kackley began his practice in Sarahsville and two years later moved to Adena where he continued in prac-

tice until 1942 with time out for service during World War I. From 1942 until recently he practiced in Willard. He was a member of the Rotary Club, Chamber of Commerce, American Legion and an elder in the Presbyterian Church. Surviving are his widow and a son.

Herbert A. Mahrer, M. D., Cleveland; Western Reserve University, 1917; aged 66; died July 16; member of the Ohio State Medical Association, the American Medical Association, the Radiological Society of North America and the American College of Radiology; diplomate of the American Board of Radiology. Dr. Mahrer spent his entire medical career in Cleveland as a member of the staff of Mt. Sinai Hospital. For 12 years preceding his retirement he was chief of the Department of Radiology of Mt. Sinai Hospital. He served as president of its Medical Council for two years. He is survived by his widow.

Clarence E. Northrup, M. D., McConnellsville; Starling Medical College, Columbus, 1905; aged 79; died July 8; member of the Ohio State Medical Association and the American Medical Association.

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trade mark, brand of Phenformin

the "full-range" oral hypoglycemic agent...
lowers blood sugar in mild, moderate, and
severe diabetes, in children and adults

FOR MORE DEPENDABLE RESPONSE, start your patients on DBI—entirely different from the sulfonylureas in chemical structure, mode of action and spectrum of activity...usually effective in low dosage range (50 to 150 mg. per day).

3 out of every 4 stable adult diabetics are satisfactorily and comfortably regulated with DBI.

2 out of every 3 brittle diabetics (juvenile or adult) enjoy better stabilization and easier management with combination of DBI and injected insulin. The smooth, gradual onset of blood-sugar lowering action helps prevent dangerous shifts between hypoglycemic reactions and hyperglycemic keto-acidosis.

sulfonylurea failures—secondary failures and primary resistant patients may respond to DBI alone, or combined with a sulfonylurea.

no clinical toxicity in over 3000 patients studied closely for varying periods up to nearly three years.

On a "start-low-go-slow" dosage pattern, DBI is relatively well tolerated. Gastrointestinal reactions occur most frequently in dosages exceeding the practical maximum 150 mg. daily, but abate promptly upon reduction of dosage or withdrawal of DBI.

The physician prescribing DBI should be thoroughly familiar with its indications, dosage, possible side effects, precautions and contraindications, etc.

DBI (N^1 - β -phenethylbiguanide HCl) is available as white, scored tablets of 25 mg. each, bottle of 100.

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Dr. Northrup moved his practice to McConnellsville in 1919 and continued there in practice until his retirement in 1951. For many years also he was Morgan County health commissioner. Affiliations included memberships in the S. E. Ohio Riding Club, the Methodist Church, Rotary Club, Grange, Friends of the Land and several Masonic bodies. Survivors include his widow and three sons,—Dr. Edgar Northrup and Dr. Deane H. Northrup, both of Marietta, and Dr. Wayne Northrup of McConnellsville.

Holley H. Pansing, M. D., Dayton; Medical College of Ohio, Cincinnati, 1905; aged 78; died July 27; former member of the Ohio State Medical Association. Dr. Pansing was Montgomery County's first health commissioner when he took the post in 1920, and served in that capacity for 37 years. A report he co-authored in the early 1930's on immunization drew international attention. Surviving are his widow, two sons, a sister and a brother.

Frank O. Perry, M. D., Norwood; Medical College of Ohio, Cincinnati, 1899; aged 85; died July 8; former member of the Ohio State Medical Association. Dr. Perry served all of his professional career in the Norwood area and was among the first physicians to receive the OSMA 50-Year Award. Active in numerous civic functions, he helped found the local Board of Health and served as city health officer. Affiliations included membership in the Masonic Lodge. His widow survives.

Edward R. Schoolfield, M. D., Bucyrus; Medical College of Ohio, Cincinnati, 1899; aged 82; died July 18; member of the Ohio State Medical Association and the American Medical Association. Dr. Schoolfield moved his practice from Charleston, W. Va., to Bucyrus in 1911 and continued there in practice until early this year when he retired. He was a veteran of World War I, having served in the Army Medical Corps. Affiliations included memberships in the Rotary Club, Elks Lodge, American Legion and several Masonic bodies. Survivors include his widow, a daughter and a son, Dr. Clarence B. Schoolfield, of Upper Sandusky.

Raymond G. Schutte, M. D., Kenton; Ohio State University College of Medicine, 1915; aged 71; died July 19; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons and the International College of Surgeons. A native of Kenton, Dr. Schutte served all of his professional career there with time out for service in the Medical Corps during World War I. A former county coroner, he was active in numerous

local affairs; was a member of several Masonic bodies, the Elks and Moose lodges, the American Legion and the Church of Christ. One of his major interests was local youth activities. Surviving are his widow and a sister.

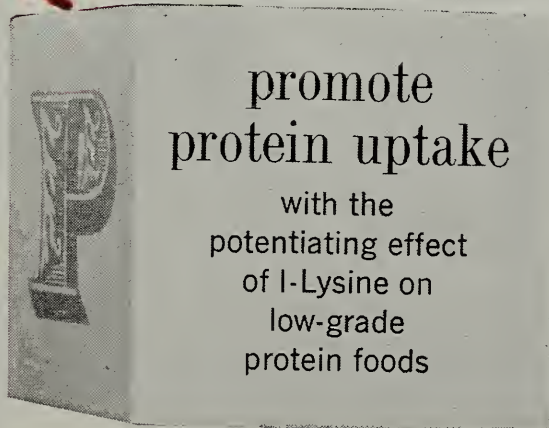
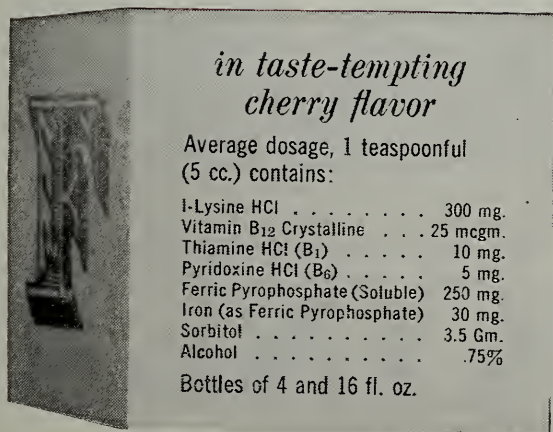
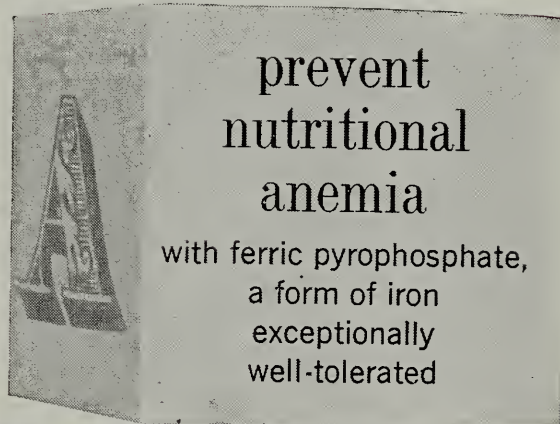
Chester C. Shinbach, M. D., Columbus; Ohio State University College of Medicine, 1930; aged 51; died July 30; member of the Ohio State Medical Association, the American Medical Association and the American Academy of Orthopaedic Surgery; diplomate of the American Board of Orthopaedic Surgery. Dr. Shinbach practiced orthopaedic surgery in Columbus until illness forced his retirement a number of years ago. He was a member of the Temple Israel. Surviving are his widow, two sons, his parents, a brother and a sister.

James Clinton Staats, M. D., Cincinnati; Eclectic Medical College, Cincinnati, 1917; aged 66; died July 1; member of the Ohio State Medical Association and the American Medical Association. A practicing physician in Cincinnati for some 33 years, Dr. Staats recently was making his residence in Mentor, Ky. Surviving are his widow, a son, two daughters, three sisters and a brother.

Ernest V. Stewart, M. D., Cincinnati; Eclectic Medical College, Cincinnati, 1924; aged 70; died July 5 in the crash of his private plane; member of the Ohio State Medical Association and the American Medical Association. A practicing physician in Cincinnati for many years, Dr. Stewart was a member of the Greater Cincinnati Airmen's Club and was in charge of the medical section of the local Civil Air Patrol. A daughter survives.

Joseph N. Weller, M. D., Ft. Lauderdale, Fla.; Jefferson Medical College of Philadelphia, 1901; aged 81; died July 11; former member of the Ohio State Medical Association; past-president of the Summit County Medical Society. Dr. Weller practiced in Akron from the completion of his medical training until 1945 when he retired and moved South. He was active in the local Tuberculosis Association and in foundation of the local Blue Cross plan in the Akron area. A member of the Masonic Lodge and the Congregational Church, he is survived by his widow, a son and a step-daughter.

I. Edward Wolfson, M. D., Huntington Park, California; University of Cincinnati College of Medicine, 1931; aged 64; died July 27. Dr. Wolfson left Ohio shortly after completing his medical schooling and practiced for a number of years in California. Surviving in the Cincinnati area are his mother, two brothers and two sisters.



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New Members of OSMA

The following are the names of the new members of the Ohio State Medical Association since July 1, 1959. The list shows the county in which they are affiliated, city in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

Auglaize County

Ziegenbusch, Kenneth H.,
New Bremen

Cuyahoga County

DeCarvalho, Sergio M.,
Cleveland
Hopkins, Robert W.,
Cleveland
Lim, Fernando, Cleveland
May, Rupert H., Cleveland

Darke County

Blickenstaff, Delbert,
Versailles

Franklin County

Terry, John L., Columbus

Hamilton County

Boyd, Gerald E., Cincinnati
Levitas, John R., Cincinnati
Singer, Lillian P., Cincinnati
Spraul, James H., Cincinnati
Wehr, Raymond E.,
Cincinnati

Lorain County

Bartone, John N., Elyria
Bruce, James E., Elyria

Lucas County

Dziad, P., Toledo
Siddall, H. Stewart, Jr.,
Toledo

Sandusky County

Ball, James B., Bellevue

Scioto County

Doerr, Mary E., Portsmouth

Union County

Linscott, John, R.,
Marysville

Wayne County

Watkins, Richard J.,
Wooster

Wyandot County

Goyne, Robert E.,
Upper Sandusky

Western Reserve Medical School and University Hospitals Share in Large Gift

A \$20,000,000 gift from the Leonard C. Hanna Jr. Fund to Western Reserve University's School of Medicine and University Hospitals of Cleveland will be used for building and endowment purposes according to officials of the two institutions. Each institution will receive \$10,000,000.

Fund trustees Harold T. Clark, John C. Virden and Lewis B. Williams said the gift was in recognition of the joint development program of the medical school and the hospitals. The medical center had long been an interest of Mr. Hanna.

Chairman of the University Medical Center Development Committee is George M. Humphrey, former U. S. secretary of the treasury. Under his leadership the group hopes to raise \$40,000,000 in the next 10 years to expand the joint facilities of the WRU School of Medicine and University Hospitals.

Director of the committee is Dr. Joseph T. Wearn, who becomes WRU vice-president for medical affairs on September 1 after serving as dean of the school of medicine since 1945.

WRU President John S. Millis said that approximately \$7,000,000 of the \$10,000,000 gift designated for Reserve would go into the endowment fund to increase medical faculty salaries. The balance will go with matching federal funds to modernize the present medical school building

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and to erect an additional five-story structure. According to Dr. Millis, \$1,300,000 of the matching federal funds have been received to date.

Stanley A. Ferguson, director of University Hospitals, said that the \$10,000,000 coming to his organization would be used for buildings and equipment.

On August 12, 1941, Leonard C. Hanna Jr. incorporated the Hanna Fund. He served as president of the board of trustees until his death in October, 1957. He was succeeded by Clark. The group changed its name to the Leonard C. Hanna Jr. Fund earlier this year.

Osteopathic Association Rejects AMA Teaching Proposal

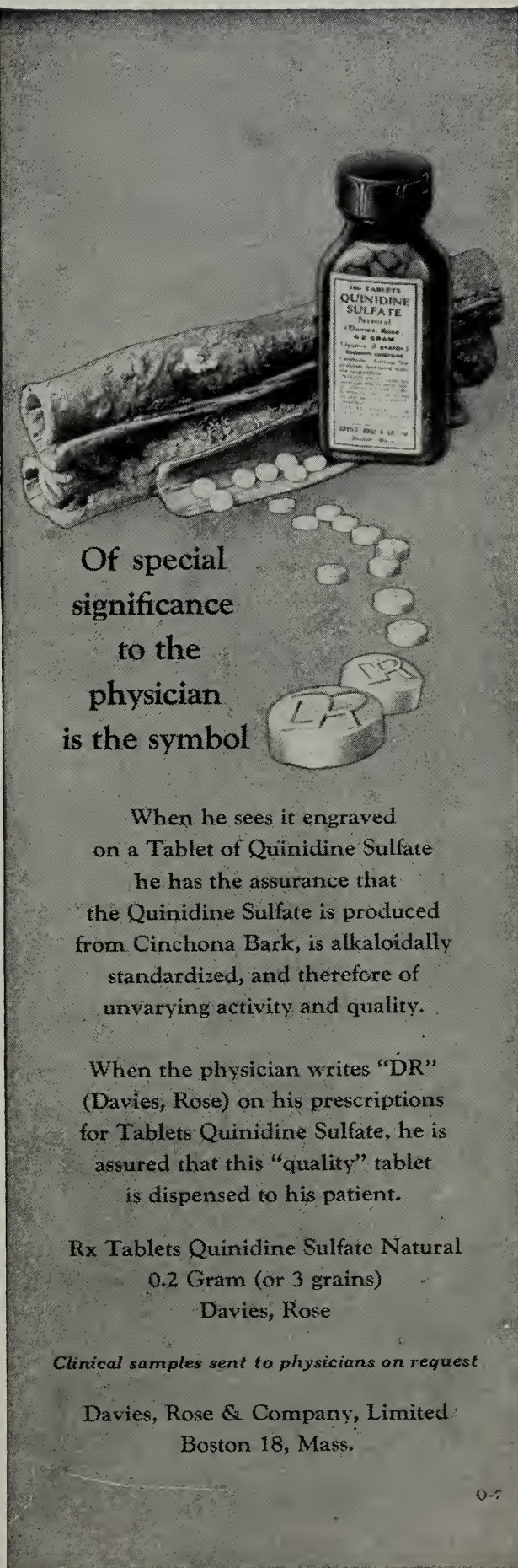
At the AMA Atlantic City meeting this year, the House of Delegates adopted a statement that it would not be considered contrary to the Principles of Medical Ethics for doctors of medicine to teach students in an osteopathic college which is in the process of being converted into an approved medical school under the supervision of the AMA Council on Medical Education and Hospitals.

Considering this matter, the American Osteopathic Association House of Delegates meeting in Chicago July 12, adopted a resolution which read, in part, as follows:

"That the osteopathic school of medicine in the interest of providing the best possible health care to the public shall maintain its status as a separate and a complete school of medicine, cooperating with all other agencies and groups that sincerely promote the same objective when that cooperation is on an equal basis granting full recognition to the autonomy and contribution of the osteopathic school of medicine."

George W. Northrup, D. O., the then President of the American Osteopathic Association, in a speech preceding the adoption of the resolution said that the crux of the osteopathic objection to the position of the American Medical Association rests in the AMA's stipulation that the six osteopathic colleges must come under the AMA's supervision before M. D.'s can teach in them. He asserted, "This is too great a price to pay for acceptance."

On July 14, the association's "Conference Committee" made a report which was adopted by the House of Delegates the substance of which was that the committee believes there should be continued discussions of interprofessional affairs with the American Medical Association.



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Report New Index System For Medical Literature

The American Medical Association and the United States Public Health Services' National Library of Medicine in Washington have announced jointly that, beginning January 1, 1960, they will institute a new program for the indexing of medical literature which is estimated at 220,000 articles annually.

The new system, which calls for mechanizing the composition of the index itself, will not only speed up the reference service to physicians, but it will also be less costly.

Here is how the new indexing system will work:

- The American Medical Association will discontinue publication of its *Quarterly Cumulative Index Medicus*, compiled by the library staff. This Index served as an invaluable aid to physicians, teachers, editors and writers, students and libraries since it was started in 1916.

- The *Current List of Medical Literature*, published by the National Library of Medicine, will be expanded in coverage to include currently published medical periodicals not covered in the past by either the National Library or the AMA.

- Beginning with the issue of January 1960, the *Current List of Medical Literature* will appear in a revised format, using improved composition techniques, and will be renamed *Index Medicus*. The new *Index Medicus* will be published monthly by the National Library of Medicine, and will be available on a subscription basis through the Superintendent of Documents, Government Printing Office.

- The AMA will publish annual cumulated volumes of the new index, which will be known as the *Cumulated Index Medicus* beginning with the volume for the calendar year 1960. The AMA will bear the cost of publishing the *Cumulated Index Medicus*, independently of the National Library. In publishing this index the AMA will use cumulative copy, in the form of film negatives, prepared and furnished by the National Library of Medicine. The mechanized system will revolve around a new type camera which is capable of photographing text material at the rate of 230 cards per minute.

New editor of *The Journal of the AMA* is John H. Talbott, M.D., professor of medicine, University of Buffalo School of Medicine who also will head the AMA's Division of Scientific Publications. He will take over on October 20. Dr. J. F. Hammond who has been serving as associate editor will continue on the staff.



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Words, Words, Words! How Do You Pronounce Them?

In the complex world of medical communication, the spoken word is often taken for granted. We speak as we hear, and the pronunciation of medical terms seems to be a matter of no controversy.

However, we may go to a medical meeting and hear a speaker from another environment enunciate in a most remarkable way—or so it seems to us. But, behind our smile lies the thought, "How do you really pronounce it?"

Here is a group of familiar words that are often "mispronounced." The criterion for correct pronunciation is the "dictionary"—although not infrequently there will be conflict among the experts.

In each case, the syllable receiving emphasis is capitalized. When there are differences in preferred phonetics among the standard dictionaries, an asterisk is used. How do *you* say it?

Word	Say	Do Not Say
Abdomen	ab-DO-men	AB-do-men
Adult	a-DULT	AD-ult
Albumin	al-BU-min	AL-bu-min
Apparatus	ap-pa-RAY-tus	ap-pa-RAT-us
Caffeine	KAF-fe-in	KAF-feen
Cerebral	SER-e-bral	se-REE-bral
Citrate	SIT-rate	SI-trate
Data	DAY-ta	DAT-ta
Digitalis	dij-i-TAL-is	di-ji-TAY-lis
Duodenum	du-o-DEE-num	du-ODD-e-num
Esophageal	e-so-FAJ-e-al	e-sof-a-JEE-al*
Fungi	FUN-ji	FUN-guy
Hemoglobin	he-mo-GLO-bin	HEE-mo-glo-bin
Ophthalmic	of-THAL-mik	op-THAL-mik
Orthopnea	or-thop-NEE-a	or-THOP-ne-a
Paresis	PAR-e-sis	pa-REE-sis*
Purulent	PU-ru-lent	POO-ru-lent
Research	re-SEARCH	REE-search
Respiratory	re-SPIR-a-to-ri	RES-pi-ra-to-ri
Roseola	ro-ZEE-o-lah	ro-se-OH-lah
Status	STAY-tus	STAT-us
Syndrome	SIN-drome	SIN-dro-me*
Vertebral	VER-te-bral	ver-TEE-bral

Printed originally in the February, 1959 issue of Physician's Bulletin, published by Eli Lilly and Company, Indianapolis; reprinted from The New Physician.

AMA Nutrition Symposium in New York To Feature Infant Feeding

Infant feeding, with special emphasis on protein, iron, calcium and phosphorus, will be the topic of an October symposium sponsored by the American Medical Association's Council on Foods and Nutrition.

The symposium, to be Tuesday, October 27, will be held at the New York Hospital-Cornell Medical Center in New York City.

Co-sponsors are New York Hospital-Cornell Medical Center, Cornell University Graduate School of Nutrition, New York Academy of Medicine, and the Medical Society of the County of New York.

Advance registration for the symposium may be made by writing to the Council on Foods and Nutrition, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.



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- low viscosity makes administration easier

DELALUTIN is also potent and safe therapy for: threatened abortion; postpartum after-pains; amenorrhea, primary and secondary; dysfunctional uterine bleeding not associated with genital malignancy; infertility with inadequate corpus luteum function; production of secretory endometrium and desquamation during estrogen therapy; premenstrual tension; dysmenorrhea; cyclomastopathy, mastodynia, adenosis and chronic cystic mastitis.

Administration and dosage:

Because of its low viscosity, Delalutin may be administered with a small gauge needle (deep intragluteal injection). Complete information on administration and dosage is supplied in the package insert.

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Delalutin is available in vials of 2 and 10 cc., each containing 125 mg. of hydroxyprogesterone caproate in sesame oil, and benzyl benzoate.

Each of these healthy, normal babies was born by a mother with a documented previous history of true habitual abortion, who was treated during her most recent pregnancy with DELALUTIN.



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New VA Committee Will Study Problems Relating to Aging Veterans

Establishment of a new agency-wide Veterans Administration committee to make an extensive study of medical, social, and economic problems of aging veterans was announced by the administrator of veterans affairs, Sumner G. Whittier.

Under chairmanship of the VA deputy administrator, Bradford Morse, the Committee on Aging will coordinate the VA's many activities and programs in the field of aging with other agencies and will make recommendations to Mr. Whittier for carrying out the nation's responsibilities to its aging veterans in the future.

As the VA Administrator and member of the cabinet-level Federal Council on Aging appointed by President Eisenhower in March, Mr. Whittier is responsible for furnishing leadership in the field of aging.

The Council is charged by the President with aiding the various Federal agencies in improving the effectiveness of their programs in the field of aging and with assisting the Secretary of Health, Education, and Welfare in planning and coordinating the White House Conference on Aging to be held in January 1961.

Halt Seen in Downward Trend Of Infant Mortality

The long-term downward trend in infant mortality has come to an abrupt—if temporary—halt, it is reported by statisticians of the Metropolitan Life Insurance Company.

There were approximately 113,000 deaths among babies under one year of age in 1958, equivalent to a rate of 26.9 per 1,000 live births. This compares with the rate of 26.4 per 1,000 in 1957 and the all-time low of 26.1 in 1956 reported by the National Office of Vital Statistics.

The record of the last two years is in sharp contrast with that of the decade between 1945-46 and 1955-56, the statisticians point out. During that period every state, without exception, succeeded in reducing its infant mortality rate.

U. S. Senate subcommittee on problems of the aged has concluded its Washington hearings and may schedule meetings throughout the country during ensuing months.

Frank H. Krusen, M. D., of Mayo Clinic will make three months study for the U. S. Office of Vocational Rehabilitation on long range medical programs and how to strengthen administrative direction of medical responsibilities of the department.



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Also available as a pleasant-tasting cherry-flavored elixir (5 mcg. per 5-cc. teaspoonful) and as REDISOL injectable, cyanocobalamin injection USP (30 and 100 mcg. per cc., 10-cc. vials and 1000 mcg. per cc. in 1, 5 and 10-cc. vials).

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Activities of County Societies . . .

CLINTON

Dr. Nathan S. Hale spoke on the subject of malignant melanoma on July 7 in the General Denver Hotel, Wilmington. Dr. Edmond K. Yantes gave a report on actions of the AMA House of Delegates in Atlantic City. Dr. Yantes is an alternate delegate to the AMA House. He further reported on a meeting in Washington, D. C., the First National Conference on Care of the Aged which he attended as chairman of the OSMA Committee on Care of the Aged.

CUYAHOGA

The July issue of *The Bulletin* of the Academy of the Academy of Medicine of Cleveland, reproduced a scroll presented to Dr. William A. Nosik, who retired as editor-in-chief of the *Bulletin* after serving in that capacity since 1956. New editor-in-chief is Dr. Leon H. Dembo.

FAIRFIELD

Dr. Joseph Ryan, professor of cardiology and medical director of the Heart Station of the Ohio State University Medical Center, Columbus, spoke at the monthly meeting of the Fairfield County Medical Society Tuesday (July 14) noon in Shaw's Restaurant, S. Broad St.

Dr. Ryan's excellently prepared paper dealt with the recent advantages in diagnosis and treatment of rheumatic fever and rheumatic heart disease.

Dr. Ryan's remarks and an analysis were well-received and greatly appreciated by the large attendance of physicians.

A lunch and short business meeting preceded the scientific portion of the meeting.—*Lancaster Eagle-Gazette*.

HAMILTON

Fall kick-off meeting of the Academy of Medicine of Cincinnati is Tuesday, September 22. Other Tuesday meeting dates are October 20, November 17, December 15, January 19, February 16, March 15, April 19 and May 24.

MAHONING

A venereal disease symposium is being planned for Youngstown, to be held on Thursday, September 24. An excellent list of speakers is being arranged by the Ohio State Department of Health.

The all day conference will be held at the Mural Room. It is to be sponsored by the American Academy of General Practice and co-sponsored by the Mahoning County Medical Society, the Ohio Department of Health and the local boards of

health. The sessions will begin at 10:00 a. m. and will offer four hours of Category I credit.

The committee to make arrangements locally consists of Dr. L. A. Blum, Dr. P. E. Krupko, Dr. A. W. Miglets, and Dr. Henry Schmid.

MONTGOMERY

In the lower left corner of each membership card of the Montgomery County Medical Society appears a paging number. All members have been assigned a permanent number which can be used to page the member at public functions and at other events.

SCIOTO

Dr. R. Dean Dooley, Columbus, director of physicians relations for Ohio Medical Indemnity, was guest speaker at the July 13 meeting. Dr. Dooley discussed new changes in the OMI contracts.

STARK

The *Canton Repository*, daily newspaper, and the Stark County Medical Society with the Canton Academy of Medicine, will cooperate in the program in which groups of physicians will bring the public up to date on what has been done in the treatment of various prevalent ailments.

Topics for the three forums will include:

1. Heart and circulatory ailments.
2. Cancer.
3. Arthritis and rheumatism.

The forums will be held October 14, January 13 and March 16 in Timken Vocational High School auditorium. Admission will be free. Each date is a Wednesday night.

Gervis S. Brady, public relations counsel for the Stark County Medical Society, will act as moderator for the forums.

Dr. Charles D. Houck, representing the Canton Academy of Medicine; Dr. Jerry I. Newman, representing the Stark County Medical Society, and Mr. Brady are working on arrangements for the meetings.

SUMMIT

The Barberton Brookside Country Club was the scene of a golf outing and dinner for members of the Summit County Medical Society on July 22.

The National Library of Medicine has just issued a bibliography on Arthropod-borne Encephalitis. Copies may be obtained at no cost upon request to the Acquisition Division, National Library of Medicine, 7th Street and Independence Ave., S. W., Washington 25, D. C.



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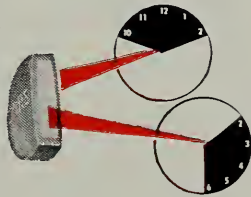
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dissolves within minutes
to produce 3 to 4 hours
of relief

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to give 3 to 4 *more* hours
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Phenylpropanolamine HCl50 mg.
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Pyrilamine maleate25 mg.

One-half of this formula is in the outer layer, the other half is in the core.

Dosage: One tablet in the morning, mid-afternoon and at bedtime.

References: 1. Lhotka, F. M.: Illinois M. J. 112: 259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

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TRIAMINIC SYRUP is recommended for adults and children who prefer liquid medication. Each 5 ml. tsp. is equivalent to $\frac{1}{4}$ of a Triaminic Tablet. *Adults:* 2 tsp. 3-4 times a day; *children 6-12:* 1 tsp. 3-4 times a day; *children under 6:* in proportion.

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* * *

Reviews of Medical Motion Pictures. Contains reprints of all reviews published in *The Journal* of the AMA during 1958. Write Film Library, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

* * *

Bibliography of Space Medicine. Lists space medicine articles, publications covering broad subject classes, including general topics, sealed cabin problems, acceleration/deceleration, fractional and zero gravity, cosmic radiation, survival problems, psychological, social, ground crew problems and extraterrestrial aspects. (35 cents). Write U. S. Government Printing Office, Division of Public Documents, Washington 25, D. C.

* * *

The Mentally Retarded Child at Home. This 98-page guide for home training of the mentally retarded was written at request of parents and physicians by U. S. Children's Bureau specialist. (35 cents) Write Superintendent of Documents, Washington 25, D. C.

* * *

You Are Not Alone. This guide to sources of care and treatment for crippled persons is designed to help parents acquaint themselves with the many types of professional, voluntary agency and federal services available. Write National Society for Crippled Children and Adults, 2023 West Ogden Avenue, Chicago 12, Illinois.

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The Pill That Could Change America. This compilation presents the most up-to-date review of socialized medicine's status throughout the world today. Write AMA, 535 North Dearborn Street, Chicago 10, Illinois.

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As Others See Us. Joint National Education Association - AMA guide helps young men and women orient themselves to the realities of adult living (10 cents). Write AMA, 535 North Dearborn Street, Chicago 10, Illinois.

Cook County Graduate School of Medicine

INTENSIVE POSTGRADUATE COURSES

STARTING DATES — FALL, 1959

SURGERY—Surgical Technic, two weeks, Oct. 19. Nov. 30. Surgery of the Colon & Rectum, one week, Oct. 26. Gallbladder Surgery, three days, Nov. 2. Surgery of Hernia, three days, Nov. 5. General Surgery, one week, Oct. 26, two weeks, Dec. 7. Board of Surgery Review Course, Part I, two weeks, Oct. 5. Blood Vessel Surgery, one week, Nov. 30. Fractures & Traumatic Surgery, two weeks, Oct. 12.

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, Sept. 28. Vaginal Approach to Pelvic Surgery, one week, Oct. 12. General & Surgical Obstetrics, two weeks, Nov. 2.

MEDICINE—Electrocardiography, Two - Week Basic Course, Oct. 5. Gastroscopy & Gastroenterology, two weeks, Nov. 3. Internal Medicine, two weeks, Oct. 19.

UROLOGY—Two-Week Intensive Course, Oct. 26. Ten-Day Practical Course in Cystoscopy, by appointment.

RADIOLOGY—Diagnostic Radiology, Two Weeks, Nov. 30.

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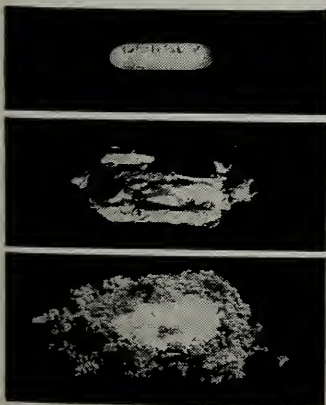
MAINTENANCE THERAPY WITHOUT STEROIDS IS FUNDAMENTAL

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Buffered Pabirin is formulated to provide high and sustained salicylate blood levels. Each tablet consists of an outer layer containing a buffer (aluminum hydroxide), para-aminobenzoic acid, and ascorbic acid; a core of acetylsalicylic acid.

In the stomach, the outer layer quickly releases the buffer, which protects against nausea, dyspepsia and other gastrointestinal symptoms so frequently encountered with salicylates alone. The core of Buffered Pabirin then disintegrates rapidly, permitting rapid absorption of the acetylsalicylic acid for faster pain relief.



Photographs show 2-stage
Tandem Release disintegration.

Each tablet contains:

Acetylsalicylic acid (5 gr.).....300 mg.
Para-aminobenzoic acid (5 gr.).....300 mg.
Ascorbic acid 50 mg.
Dried aluminum hydroxide gel.....100 mg.

All Buffered Pabirin is sodium- and potassium-free.

Dosage: Two or three tablets
3 or 4 times daily.

References: 1. Hart, D.; Bagnall, A. W.; Bunim, J. J., and Polley, F. H.: Ninth International Congress on Rheumatic Diseases, Toronto, Ont. (June 25) 1957. 2. Report of Joint Committee, Medical Research Council & Nuffield Foundation, Treatment of Rheumatoid Arthritis, British Medical Journal (April 13) 1957. 3. Friend, D. G.: New England J. Med. 257:278 (Aug.) 1957.

Buffered **Pabirin[®]** *Tablets*

COMING MEETINGS

Academy of Psychosomatic Medicine, Sheraton-Cleveland Hotel, Cleveland, October 15-17.

American Medical Association, Clinical Session, Dallas, Texas, November 3-6.

American Association of Medical Assistants, Benjamin Franklin Hotel, Philadelphia, Pa., October 16-18.

American College of Surgeons, Traymore Hotel, Atlantic City, September 28-October 2.

American College of Surgeons, Ohio Chapter, Statler Hotel, Cleveland, September 11-12; Dr. Berton M. Bogle, 311 S. Market St., Troy, Ohio, Secretary-Treasurer.

American Heart Association, Annual Meeting and Scientific Sessions, Philadelphia, October 23-27.

American Hospital Association, 61st Annual Meeting, New York City Coliseum, August 24-27.

American Medical Writers' Association, Chase Hotel, St. Louis, October 2-3. Dr. Harold Swanberg, 510 Maine St., Quincy, Ill., Secretary.

American Roentgen Ray Society, Netherland Hilton Hotel, Cincinnati, September 22-25; Dr. C. Allen Good, Mayo Clinic, Rochester, Minn., Secretary.

Cleveland Academy of Medicine, Seminar on Recent Advances in Diagnosis and Therapy of Malignant Diseases, November 18-19.

Columbus Academy of Medicine, Clinic Day, October 21.

Course in Pulmonary Diseases, Ohio State University College of Medicine, Columbus, September 25-26.

Eighth Councilor District, Meeting and Scientific Program, Lancaster, October 8.

Kentucky State Medical Association, Louisville, Ky., September 22-24.

Medical Society of the State of Pennsylvania, Penn-Sheraton Hotel, Pittsburgh, October 18-23.

Northwestern Ohio Medical Association, Findlay Country Club, October 7, all-day session; registration 9:00 a.m.; first speaker, 9:45 a.m.

Ohio Academy of General Practice, Annual Scientific Assembly, Columbus, September 16-17.

Second District Postgraduate Program, Springfield, October 21.

Sixth Councilor District Postgraduate Day, Springfield, October 21.

Symposium on Therapy of Acute Injuries, AMA Council on Drugs, Cleveland, October 7.

Division of Indian Health of U. S. Public Health Service is being moved to Denver to put the staff closer to the Indian reservations.

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JACKSON—Tom Washam, President, 35 Vaughn St., Jackson; Brinton J. Allison, Secretary, 267 Ralph St., Jackson. Called meetings.

LAWRENCE—Gerard C. Geswein, President, 1626 S. Sixth St., Ironton; George Newton Spears, Secretary, 422 South Sixth Street, Ironton. Monthly meetings on call.

MEIGS—Charles J. Mullen, President, 210½ E. Main St., Pomeroy; Selim J. Blazewicz, Secretary, 112½ E. Main St., Pomeroy. Last Wednesday, monthly.

PIKE—Paul H. Jones, President, Stockdale; George W. Cooper, Secretary, Box 215, Piketon. 1st Tuesday, monthly.

SCIOTO—Ralph W. Lewis, President, 1025 Ninth St., Portsmouth; Carl H. Laestar, Secretary, 2829 Gallia St., Portsmouth. 2nd Monday, monthly.

VINTON—Richard E. Bullock, President, McArthur.

TENTH DISTRICT

DELAWARE—Max W. Livingston, President, 28 North Vernon, Sunbury; Edward C. Jenkins, Secretary, c/o Mrs. Mabel Barrett, Jane M. Case Hospital, Delaware. 3rd Tuesday, monthly.

(Continued on Next Page)

COUNTY SOCIETIES' OFFICERS AND MEETING DATES (Continued)

FAYETTE—H. Wm. Payton, President, 36 S. Main St., Jeffersonville; Marvin H. Roszmann, Secretary, 107 N. North St., Washington C. H. 2nd Tuesday, monthly.

FRANKLIN—James L. Henry, President, 244 E. Park St., Grove City; Mr. William Webb, Executive Secretary, 79 East State Street, Columbus 15. Meetings in January, February, March, May, September, November and December.

KNOX—Henry T. Lapp, President, 4 Public Square, Mt. Vernon; Thomas L. Bogardus, Secretary, 50 Public Square, Mt. Vernon. Quarterly meetings.

MADISON—William T. Bacon, President, 40 E. First St., London; Paul G. H. Wolber, Secretary, 40 E. First St., London. 2nd Wednesday, monthly.

MORROW—Andrew Maciurak, President, 119 E. Main St., Cardington; William S. Deffinger, Secretary, Marengo. First Tuesday, monthly.

PICKAWAY—Henry H. Swope, President, 233 N. Court St., Circleville; Edward L. Montgomery, Secretary, 108 Seyfert Ave., Circleville. 1st Friday, monthly.

ROSS—Robert E. Quinn, President, 30 N. Walnut St., Chillicothe; G. Howard Wood, Secretary, 134 W. Main St., Chillicothe. 1st Thursday, monthly.

UNION—Paul R. Zaugg, President, 130 N. Maple St., Marysville; May B. Zaugg, Secretary, 130 N. Maple St., Marysville. 2nd Tuesday, monthly.

ELEVENTH DISTRICT

ASHLAND—R. Lee Schafer, President, 203 Maple Street, Ashland; Wayne C. Smith, Secretary, 1060 Claremont Ave., Ashland. 1st Friday, monthly, except July, August.

ERIE—Richard F. Hoffman, President, Providence Hospital, Sandusky; Edward P. Gillette, Jr., Secretary, 410 Columbus Ave., Sandusky. Monthly meeting date varies.

HOLMES—Clyde Bahler, President, Walnut Creek; Luther W. High, Secretary, R. F. D. 4, Millersburg. 2nd Wednesday, monthly.

HURON—Walter A. Drury, President, Box 269, Willard; John V. Emery, Secretary, Box 269, Willard. 2nd Wednesday, March, June, September and December.

LORAIN—Denis A. Radefeld, President, 209 Sixth St., Lorain; Mrs. C. Ruth Zealley, Executive Secretary, 311 Elyria Block, Elyria. 2nd Tuesday, monthly.

MEDINA—Robert E. Smith, President, 403 East Liberty St., Medina; William G. Halley, Secretary, 115 Bank Street, Lodi. 3rd Thursday, monthly.

RICHLAND—Riley E. Frush, President, 36 S. Mulberry St., Mansfield; James O. Ludwig, Secretary, 336 Sturges Ave., Mansfield. 3rd Thursday, monthly.

WAYNE—Ralph I. Cottle, President, 230 N. Market St., Wooster; Robert E. Schulz, Secretary, Wooster Community Hospital, Wooster. 2nd Wednesday, monthly.

THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

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- * Relieves burning in minutes
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LOCALIZED MUCOSAL ANALGESIA

Phenylazo-diamino-pyridine HCl--acts solely on the urogenital mucosa; provides prompt relief from burning, pain and frequency.

LOCALIZED ANTIBACTERIAL ACTIVITY

Sulfacetamide--eliminates mixed infections rapidly because of its unusual solubility in acid urine common to bacterial invasion of the urinary tract. No renal damage, concretions or anuria.


...and when Spasmolysis is essential

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Antibacterial • Analgesic • Antispasmodic

—the dual activity of SULFID with the well-known antispasmodic effect of natural belladonna alkaloids.

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*whenever there is inflammation,
swelling, pain*

VARIDASE[®]

STREPTOKINASE-STREPTODORNASE LEDERLE

BUCCAL Tablets

conditions for a
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as in acute
hemorrhoids...

SUNDAY, 9 A.M.: VARIDASE for painful thrombotic hemorrhoid. 2:30 P.M.: pain greatly reduced, less swelling and inflammation.

MONDAY: size down to small tab; acute inflammation disappeared.*

VARIDASE activates natural fibrinolytic factors, to limit undesirable inflammatory response and speed healing.

Dramatic reduction of pain is often the first sign of improvement; swelling and redness rapidly diminish. Drugs and natural regenerative factors readily penetrate the inflammatory barrier to effect total remission faster... in trauma or infection.

VARIDASE Buccal Tablets contain:
10,000 Units Streptokinase, 2,500 Units Streptodornase.
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*Peterman, R. A.: Clinical report cited with permission.



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The Physician's Bookshelf

(Books received from publishers. *The Journal* is not obligated to list herein every book received. It will try to list those which appear to be of greatest interest.)

* * *

Company Medical and Health Programs, by National Industrial Conference Board, Inc. (\$3.00 for Conference Board Associates; \$20.00 for non-Associates, *National Industrial Conference Board, Inc., 460 Park Ave., New York 22, N. Y.*) This is one of the board's studies in personnel policy, prepared by Doris M. Thompson, division of personnel administration. It contains a wealth of valuable material and is to some extent a revision of a similar study made in 1948. Only company-operated programs are covered—not union clinics, etc. United States firms numbering 242 and 36 Canadian firms provided data on which the report is based; in addition, many more companies permitted representatives of the board to study their medical departments and services. Subjects covered in the report include the following: Why a company health program?; setting the basic policy; the scope of the company medical services; who provides the services?; the medical unit in the organization; physical layout and equipment. There is a generous display of tables, charts, drawings, etc. Here is an excellent reference brochure for physicians engaged in the practice of industrial medicine or those who are serving as part-time advisers to companies on industrial health matters.

When A Family Faces Cancer; Public Affairs Pamphlet No. 286, by Elizabeth Ogg. (25 cents, *Public Affairs Pamphlets, 22 E. 38th St., New York 16, N. Y.*) This pamphlet is designed to assist the families of cancer patients to meet the difficult physical and psychological problems connected with that disease. It is written by Elizabeth Ogg with the assistance of several medical groups specializing in cancer research and treatment and is the latest of the nonprofit Public Affairs series.

Physicians may wish to secure a copy for evaluation and, if it meets the test, get a supply for distribution to the families of cancer patients.

Synopsis of Ophthalmology, by William H. Havener, M. D., professor in the Department of Ophthalmology, Ohio State University, Columbus, Ohio. (\$6.75, *The C. V. Mosby Company, St. Louis 3, Mo.*)

Principles of Disability Evaluation, by Wilmer Cauthorn Smith, M. D. (\$7.00, *The J. B. Lippincott Company, Philadelphia 5, Pa.*)

Children in Practice, by John Peterson. (\$4.75, *Cambridge University Press, New York 22, N. Y.*)

The Care of Minor Hand Injuries, by Adrian E. Flatt, M. D. (\$9.50, *The C. V. Mosby Company, St. Louis 3, Missouri.*)

Manual of Chest Clinic Practice in Tropical and Subtropical Countries, by A. J. Benatt, M. D. (\$3.00, *The Williams & Wilkins Company, Baltimore 2, Maryland*, exclusive U. S. distributors.)

What Next, Doctor Peck?, by Joseph H. Peck, M. D. (\$3.50, *Prentice-Hall, Inc., Englewood Cliffs, N. J.*)

Treatment of Lung Cavities and Endobronchial Tuberculosis, by Beryl E. Barsby, M. D. (\$4.75, *The Williams & Wilkins Company, Baltimore 2, Md.*, exclusive U. S. distributors.)

Re-education of the Injured Shoulder, by R. Barrie Brookes. (\$3.50, *The Williams & Wilkins Company, Baltimore 2, Md.*, exclusive U.S. agents)

The Annual Survey of Psychoanalysis: Volume V, by John Frosch, M. D., and Nathaniel Ross, M. D. (\$12.00, *International Universities Press, Inc., New York 11, New York.*)

Anesthesia for Infants and Children, by Robert M. Smith, M. D. (\$12.00, *The C. V. Mosby Company, St. Louis 3, Missouri.*)

Comparative Endocrinology, by Aubrey Gorman. (\$15.00, *John Wiley & Sons, Inc., New York 16, N. Y.*)

Atlas of Human Anatomy, by Frohse-Brodel. (\$2.95 (paper), \$4.50, (cloth), Fifth Edition, *Barnes & Noble, 105 Fifth Avenue, New York 3, New York.*)

Living Beyond Your Heart Attack, by Eugene B. Mozes, of Canton, Ohio. (\$3.50, *Prentice-Hall, Inc., New York 11, New York.*)

Synopsis of Treatment of Anorectal Diseases, by Stuart T. Ross, M. D. (\$6.50, *The C. V. Mosby Company, St. Louis 3, Missouri.*)

Staphylococcus Bibliography

National Library of Medicine has issued a supplement to its bibliography on staphylococcal infection. Copies may be obtained without charge by writing to the Acquisition Division, National Library of Medicine, Washington 25, D. C.



NABCON

"ESSENCE OF BREWER'S YEAST"

NABCON concentrates in one tasty teaspoonful all the active components of 35 brewer's yeast tablets.

Now you can give your patients the full range of B complex *natural* vitamins as presented by brewer's yeast . . .

Leading authorities always have recognized the value of brewer's yeast, but the necessity of giving a patient 30 to 40 large tablets a day has limited the usefulness of this valuable vitamin source. Now—one teaspoonful of NABCON a day will give the same results—results often significantly superior to synthetic B complex mixture.

Whether the patient is 3 years or 80 years old, for gratifying clinical response and willing patient co-operation, prescribe NABCON in 4 oz. bottles—a month's supply.

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WORCESTER, MASS.

*Have you
tasted NABCON?
It's really pleasant.
Send for samples.*

You and Your Public

Physician Can Remove Patients' Fear of the Unexpected and Their Anxiety Over Charges through Pre-Hospitalization Counseling

"I GOT these bills from two other doctors after my operation and I never heard of them." This often-heard grievance is not only bad public relations for the patient's physician but for the profession as well. Most of all, however, it is entirely unnecessary and can readily be avoided.

The physician who discusses in detail the patient's forthcoming hospitalization is practicing good public relations—and good medicine, particularly if it is the patient's first hospital experience.

Through this counseling he is removing fear of what to expect, concern about medical care costs, worry over "what's going to happen to me."

Most important, this counseling prevents what to the unsuspecting patient may be a shock when he receives a bill from the surgical assistant and the anesthetist. The informed patient knows his physician has had an assistant. He knows this is good medicine and for his benefit. He knows that the trained anesthetist is performing a valuable professional service.

A discussion of hospital routine and regulations also is very much in order. Hospital life is hardly considered as the ordinary routine of day-to-day living. Understanding the routine helps the patient to adapt himself to it. He is oriented, enjoys a better frame of mind than if it were all unknown, and he is a better patient.

The physician would do well to wind up his counseling session by telling the patient that "if something happens that upsets you, please let me know immediately."

It should be remembered that when the physician asks the patient to enter the hospital, he is in effect saying, "Put yourself in my hands." The patient puts his trust in his doctor and the doctor, in accepting this trust, also accepts responsibility for his patient. This responsibility goes beyond just the physician's immediate and direct care of the patient.

This is an important point to remember, and recent surveys indicate that it needs to be remembered. These surveys indicate that more than a few patients feel that they could have been accorded a little more consideration when hospitalized.

Some of the complaints were because of noise, rudeness, cold or poor food, loud talking, curt-

ness. Whether real or imagined, the thinking physician will investigate his patient's complaints.

A long stride toward solution of the problem has been taken by the Orange County (California) Medical Society to avert grievances. This society has produced a printed form which the physician hands the patient just prior to hospitalization. The form reads:

"Patient's Name

"Your surgery has been scheduled at.....
Hospital on You should enter
the hospital between the hours of 1:30 and 3:00
p.m. on The estimated
duration of your hospital stay is days.

To Assist You in Planning Your Hospitalization

"Medical and hospital expenses are seldom welcomed, but knowing in advance what to expect and how to plan for them can lessen the burden.

"Professional fees: When you have major surgery, the surgical team is comprised of three physicians—the **Surgeon**, the **Assistant Surgeon**, and the **Anesthetist**—each of whom has an important part in your care. While each doctor will set his own fee, and bill you from his own office, it usually is possible to **estimate** in advance the approximate amount of these professional fees. Assuming an uncomplicated course for your surgery, the charges are estimated as follows:

"Surgeon to

"Assisting Surgeon to

"Anesthetist to

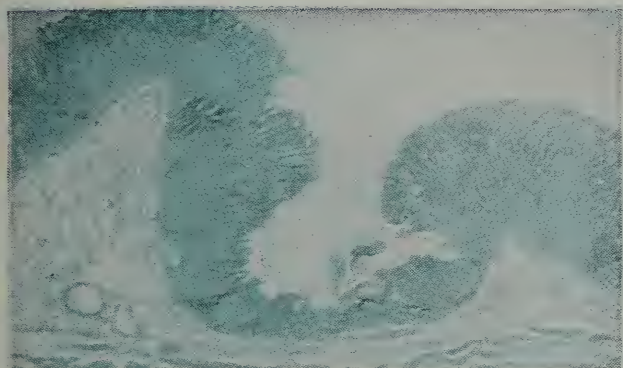
"The assisting surgeon and the anesthetist base their fees on the operating time; consequently, if a surgical procedure turns out to be more complicated than was anticipated, their fees may be correspondingly increased."

This idea may be extended by the physician by requesting the hospital or hospitals at which he holds staff privileges to provide comparable and brief forms dealing with hospital rules, regulations, rates, arrangements for payment, visiting hours, and other pertinent information.

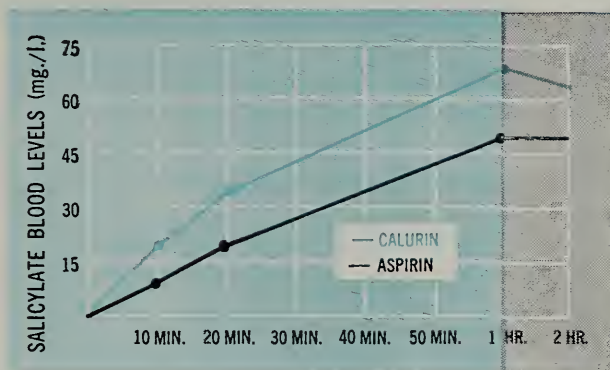
The hospital-bound patient who has received the counsel of his physician along with these two suggested forms is more likely to approach hospitalization with assurance and peace of mind.

CALURIN*

STABLE SOLUBLE CALCIUM-ACETYLSALICYLATE-CARBAMIDE



Particle-induced ulceration — section through lesion found in gastrectomy specimen. An aspirin particle was found firmly imbedded in this undermined erosion. Such lesions may be associated with the relative insolubility of aspirin, which remains in particulate form after dispersion in gastric contents.



Calurin, being freely soluble, is promptly available for absorption into the systemic circulation. Salicylate blood levels in 12 subjects receiving both Calurin and plain aspirin were found to rise more than twice as high within ten minutes following Calurin. Also, these levels persisted higher for at least two hours.¹¹

CALURIN is the aspirin of choice, especially when high-dosage, long-term therapy is indicated:

- 1 High solubility forestalls gastric irritation or damage. This advantage is of special importance in arthritis and other conditions requiring high-dosage, long-term therapy.
- 2 Produces high salicylate blood levels rapidly for prompt analgesic, anti-pyretic, anti-arthritis effect.
- 3 Sodium-free — for safer long-term therapy.
- 4 Flavored: can be chewed or dissolved in the mouth without water if desired — an advantage for patients requiring aspirin administration during the night and for pediatric patients.

Dosage: Each tablet of Calurin is equivalent to 300 mg. (5 gr.) of acetylsalicylic acid. For relief of pain and fever in adult patients, the usual dose of Calurin is 1 to 3 tablets every 4 hours, as needed; in arthritic states, 2 or 3 tablets 3 or 4 times daily; in rheumatic

fever, 3 to 5 tablets 4 or 5 times daily. For children over 6 years, the usual dose is 1 tablet every 4 hours; for children 3 to 6 years, $\frac{1}{2}$ tablet every 4 hours, as required. Not recommended for children under 3.

REFERENCES: 1. Waterson, A. P.: Aspirin and gastric haemorrhage, *Brit. M. J.* 2:1531, 1955. 2. Douthwaite, A. H., and Lintott, G. A. M.: Gastroscopic observation of the effect of aspirin and certain other substances on the stomach, *Lancet* 2:1222, 1938. 3. Editorial Comments: The effect of acetylsalicylic acid (aspirin) on the gastric mucosa, *Canad. M. A. J.* 80:47, 1959. 4. Muir, A., and Cossar, I. A.: Aspirin and ulcer, *Brit. M. J.* 2:7, 1955. 5. Muir, A., and Cossar, I. A.: Aspirin and gastric haemorrhage, *Lancet* 1:539, 1959. 6. Schneider, E. M.: Aspirin as a gastric irritant, *Gastroenterology* 33:616, 1957. 7. Bayles, T. B., and Tenckhoff, H.: Salicylate therapy in rheumatic diseases, Scientific Exhibit, Ann. Mtg. A. M. A., San Francisco, Calif., June, 1958. 8. Batterman, R. C.: Comparison of buffered and unbuffered acetylsalicylic acid, *New Eng. J. M.* 258:213, 1958. 9. Cronk, G. A.: Laboratory and clinical studies with buffered and nonbuffered acetylsalicylic acid, *New Eng. J. M.* 258:219, 1958. 10. Editorial: Aspirin plain and buffered, *Brit. M. J.* 1:349, 1959. 11. Smith, P. K.: Plasma concentration of salicylate after the administration of acetylsalicylic acid or calcium acetylsalicylate to human subjects, Report submitted to Smith-Dorsey from Dept. of Pharmacology, Geo. Washington Univ. School of Medicine, Washington, D. C., Sept. 5, 1958.

*TRADEMARK

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska

Civil Defense Review

Some Recent Developments in the CD Field And Activities in the Program

THE American Hospital Association has recommended to state hospital associations that they: assist hospitals which are not accredited by the Joint Commission on Accreditation of Hospitals in establishing disaster plans and regular disaster drills; hold institutes to provide guidance to their member institutions which are setting up disaster plans and commencing to conduct regular disaster drills; and advise all member hospitals that, when planning for new or renovated facilities, full attention should be paid to the importance of sound design of facilities which will be used for sorting and handling mass casualties.

AHA has also recommended that state hospital associations assist member hospitals which lack an emergency power service by helping them install a standby generator with the aid of a civil defense grant.

* * *

Strike

Walter Reed Army Medical Center, Washington, D. C., with the approval of the Army Surgeon General, has produced "Strike," an excellent 90-minute television dramatization of a pocket of survivors of a major nuclear weapons strike on the United States.

"Strike" depicts life at an Army post some distance from a city to which the civilian population goes after 100 major target complexes are hit without warning. The medical, health and social problems of those surviving are portrayed not as a "how-to-do-it" but to show what might happen and to make the viewer think. The individual fates of members of a elderly semi-retired physician's family are dramatically presented.

* * *

Select Committee on Civil Defense Proposed

Senator Stephen M. Young, Ohio, a frequent critic of the nation's civil defense effort, has introduced in the United States Senate, S. Res. 142, a resolution to establish a Select Committee on Civil Defense. It would be the duty of the Committee to conduct a comprehensive study and investigation with respect to the nature of the problems involved; the validity of present solutions; the effectiveness of present federal, state and local organizational structures; the extent to which current methods utilize our nation's skills, talents and resources; and legislative and other means

whereby existing civil defense organizations and programs can be improved to provide more adequate protection for the civilian population in time of war. The resolution has been referred to the Senate Committee on Rules and Administration.

* * *

Tea Antidote for Strontium 90

The New York Times reported that two Japanese scientists have announced that tea can serve as an antidote to the effects of strontium 90, a harmful isotopic product of radioactive fallout. Strontium 90 was fed to white mice. Some mice were then given a two per cent solution of tannin. Those that did not receive the tannin treatment suffered the usual harmful effects of strontium 90, which concentrates in the bones. But among the others, the tannin absorbed and carried away as much as 90 per cent of the dangerous isotope.

* * *

Mend Notes

National Coordinator of Medical Education for National Defense, Captain Bennett F. Avery, MC, USN, advises that at a joint meeting in Atlantic City, the Federal MEND Council and AAMC Committee on MEND approved the affiliation of 15 additional medical schools with the MEND program, effective January 1, 1960. The schools are: Albany, Arkansas, University of Chicago, Hahnemann, Jefferson, Minnesota, Tennessee, Utah, Wayne State, West Virginia, and Woman's Medical College of Pennsylvania. With the new additions, a total of 71 medical schools will be participating in the MEND program.

* * *

Shelters

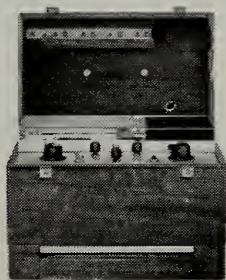
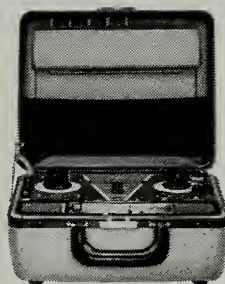
A new OCDM 32-page booklet *The Family Fallout Shelter*, includes plans for five types of shelter from radioactive fallout. The booklet, MP-15, is available in quantity through state civil defense directors. Large-scale drawings of the five plans appearing in the booklet are available on request to OCDM Operational Headquarters, Battle Creek, Michigan.

The Federal Housing Administration and other agencies make loans for the construction of fallout shelters. FHA will make Title 1 loans up to \$3,500 directly to homeowners for improvement of property, including shelters, with certain restrictions.

accent on versatility

accent on portability

**one
plus
one
equals
two**



AN ELECTROCARDIOGRAPH for maximum usefulness in your office examining room . . . and an electrocardiograph that you can easily *take with you* on any call — are the reasons Sanborn Company developed the 100 Viso and 300 Visette ECG's.

Both produce permanent, easily interpreted, diagnostically accurate electrocardiograms. Both are simple to operate . . . and both will give stable, trouble-free operation year after year. But there are also these important differences: in the 18-pound Visette, every *practical* means is used to achieve the combination of extremely light weight, brief case size and "traveling" ruggedness. In the new 100 Viso for office use, where instrument portability is not a prime requirement, the design includes such additional features as *two* recording speeds, *three* recording sensitivities, provision for recording *other* waveforms, and *visual monitoring* by an external oscilloscope.

Each of these companion cardiographs has individual emphasis in terms of *portability* and *versatility*. But both equally reflect the best principles of modern diagnostic instrument design.

SANBORN COMPANY
MEDICAL DIVISION

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Model 300 Visette, 625 dollars.

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Washington Roundup

News from the Nation's Capital of Interest to Physicians; Developments in Medical and Health Fields

Senate Judiciary Committee has criticized Veterans Administration policy, or lack of policy, in distributing information gained through research in prosthetics, particularly VA's relying on a trade association to see that this information reaches the public.

* * *

Financial reports of registered lobbyists for quarter ending June 30 include the following national associations: AMA, \$11,884; Hospital, \$11,424; Dental, \$9,303; Cancer, \$7,694; Optometric, \$3,031; Osteopathic, \$520; Arthritis and Rheumatism, \$1,249; Association of American Medical Colleges, \$1,693; AAPS, \$1,500; Michigan Hospital Service \$1,363; and Multiple Sclerosis Society, \$883.

* * *

Social Security Administration reports medical care vendor payments for June exceeded \$30 million. This refers only to Federal funds for public assistance programs, and does not include \$8.6 million in medical care given persons on poor relief, in which no Federal funds are involved. Old age assistance accounted for \$21.6 million.

* * *

Surgeon General has been directed by Congress to approve only those National Health Institutes research and training grants of high priority and promise that deferment would likely delay progress in medical discovery. He also is directed to reject applications that might bring "harmful diversion of manpower and other resources needed for teaching and medical care services," and to guard against approving grants that tend to substitute government aid for private support.

* * *

Federal funds amounting to \$11,235,480 have been granted to 47 institutions for construction of facilities for health research. Appropriations are made on a dollar-matching construction basis.

* * *

Federal Trade Commission has ordered Symon Gould book firm, New York, trading as Health Guide to cease advertising claims that cures for cancer, heart disease and arthritis lie in following directions printed in books sold by the firm. An FTC hearing examiner concluded, "The expert medical testimony shows that following the vari-

ous regimens set out in these books may, in the case of cancer or heart disease, cause or hasten death, and cause or hasten permanent crippling in some types of arthritis."

* * *

"Practice of Military Medicine: Broadening Concepts" will be the theme for the 66th annual convention of the Association of Military Surgeons in Washington, November 9 to 11.

* * *

Report of House Committee on Science and Astronautics calls for civil defense planning to include a greater effort at providing shelters against chemical, biological and radiological attack and public instruction in defense measures. Report also calls for tripling funds for research in this field.

* * *

Atomic Energy Commission has reduced its price for Iodine-131 by 20 to 25 per cent, based on quantities purchased. Also, a Medical Nuclear Consultants, Inc., advisory panel has warned civilian hospitals to prepare to handle increased numbers of nuclear accident patients. The panel called for proper examination of persons regularly exposed to radiation in their work, at the same time stating that "there are very few medical centers in this country which can perform complete examinations on such cases and perform them adequately."

* * *

Surgeon General Burney has named an ad hoc advisory committee to study anew the nations needs for mental health facilities, with emphasis on services being developed for outpatient and emergency service through hospital clinics or mental health centers, increased use of general hospitals, "half-way houses" and nursing homes.

* * *

Children's Hospital Research Foundation, Washington, D. C., reports that a chemical, carrageenin, found in seaweed has cured ulcers induced in dogs and may be found helpful in peptic ulcers and U.S. Navy physicians have found that painful warts on the bottom of the foot can be treated successfully by injections of vitamin A.

and
blood pressure
is controlled
safely and
effectively

The hypertensive under treatment is frequently burdened with side effects of therapy including states of depression, fatigue, and lethargy. He finds little joy left in his life and laughter is almost a forgotten experience.

With RAUTENSIN and RAUVERA, two unique and dependable antihypertensive agents, patients feel better, have a brighter outlook and blood pressure is safely reduced.

in mild hypertension

RAUTENSIN provides smoother antihypertensive action with no sudden rebounds or abrupt declines, and can be given over long periods of time without impairing mental alertness, producing excessive lethargy or drowsiness. When tachycardia is present, RAUTENSIN slows heart rate 10 to 15 per cent. RAUTENSIN is less likely to cause mental depression.¹ The apprehensive hypertensive is calmed, yet side actions are "... either completely absent or so mild as to be inconsequential."²

RAUTENSIN[®]

each tablet contains 2 mg. of the purified alseroxylon complex of Rauwolfia serpentina

Dosage: For the first 20 to 30 days, 2 tablets (4 mg.) once daily, at bedtime. Thereafter, a maintenance dose of 1 tablet (2 mg.) daily will suffice for most patients.

in moderate to severe hypertension

RAUVERA produces smooth and steady antihypertensive action which persists over the entire twenty-four hours without peaks and valleys... no "saw tooth" effect. Patients show a marked subjective as well as objective improvement with a significant drop in blood pressure, yet with a very low incidence of side effects.³ Abrupt rise in blood pressure does not occur even when therapy is interrupted.⁴ Tolerance does not develop on prolonged administration. Sensitization reactions or postural hypotension do not occur. Headaches, fatigue, insomnia and "heart consciousness" rapidly disappear, leaving the patient feeling well and asymptomatic.

RAUVERA[®]

each tablet contains 1 mg. of purified alseroxylon complex of Rauwolfia serpentina and 3 mg. alkavervir (Veratrum viride fraction)

Dosage: One tablet 3 or 4 times daily, ideally after meals, at intervals of not less than 4 hours.

1. Moyer, J. H.; Dennis, E., and Ford, R.: Arch. Int. Med. 96:530, 1955.

2. Terman, L. A.: Illinois M. J. 3:67, 1957.

3. La Barbera, J. F.: M. Rec. & Ann. 50:242, 1956.

4. Bendig, A.: New York J. Med. 66:2523, 1956.

In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

HAVE A DOCTOR-LAWYER CODE IN YOUR COUNTY?

Has your county medical society met with the local bar association to study, draft and adopt the physicians-lawyers code of relationship? If not, better find out why.

The code was drafted jointly by the Ohio State Medical Association and Ohio Bar Association. It charts the way for better understanding between members of the two professions. It can be put into effect in any community with few, if any, changes.

Copies may be obtained by communicating with the OSMA Columbus Office.

CHECKING UP ON REPORTS OF HOUSE OFFICERS

Some physicians object to signing or authenticating histories and physicals done by interns and residents, claiming it might be held against them, the Joint Commission on Accreditation of Hospitals states. Commenting on this, Dr. Kenneth B. Backcock, director of the Commission, makes these points:

The house officer's years are learning years. If a hospital medical staff does not supervise by reading, amending, criticizing and authenticating these documents of the house officer, they are not living up to their responsibilities.

If the history and physical is incorrect, it should be corrected immediately or it is an injustice against the patient.

Nine times out of ten a court will accept the written word as the truth, whether it was or not. The doctor, by reading, amending and authenticating the chart, is protecting himself to a far greater extent than he would by not doing it.

BACKING UP POLITICAL CONVICTIONS WITH CASH

See by the papers that the political party fund raisers are beginning to beat their drums. In case you've forgotten, 1960 is an election year.

In our opinion every Ohio physician should seriously consider making a financial contribution—big or little—to the treasury of the political party of his choice.

For the physician to shun politics is about like committing suicide. Also, it is not enough for the physician to think he has done his part by going to the polls each election day or by electioneering

for his favorite candidates. Money is needed to carry on effective political activities. Such activities need the support of good citizens and citizens who have the money to back up their convictions. Physicians qualify on both points.

In our opinion the following quotations from an editorial in *The AMA News* put the issue squarely on the line:

"Support of the party of your choice is as much an obligation as support of the Community Fund, Red Cross, or any of the other civic organizations to which you regularly contribute.

"As a matter of fact, the Republican and Democratic parties are two of this country's most vital civic organizations. If they have not always been everything we expect of them, perhaps a large part of the blame rests with ourselves.

"A growing number of business concerns not only are publicly encouraging employes to take an active role in politics, but are setting up schools to show them how to be effective at the grass roots level. Organized labor long has been deeply involved in political activity.

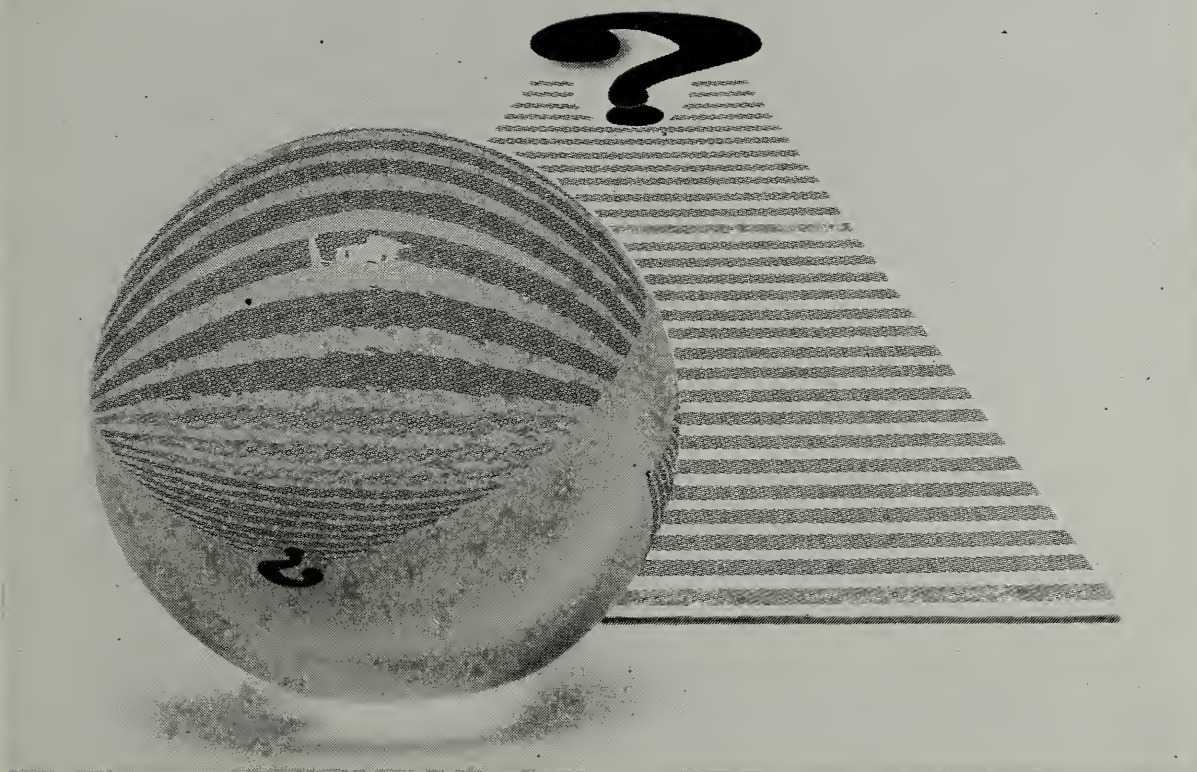
"If the professional men of America do not become more active in government and politics and do not join in concerted resistance to further inroads on local authority and initial initiative, they will be doing less than citizenship demands of them."

KEEP YOUR EYE ON BILLING PROCEDURES

Heard the other day of a case where the family got a bill for services rendered by the surgeon almost before the patient came out from under the anesthetic. Sure, it happened near the end of the month and the professional management service employed by the surgeon followed the customary routine of billing his patients on the first of the month.

Be that as it may, the case illustrates that book-keeping and billing services, necessary as they be, can't take the place of direct physician-patient relationship. It emphasizes this point, also: It behooves the physician still to take a personal active interest in the overall operations and activities of his office and to supervise those to whom he sublets certain services.

In our opinion, there are few physicians who would send a bill for services rendered while the patient still is in a will-he or won't-he get well



what lurks beyond the broad spectrum?

"Broad spectrum" has evolved into an especially apt term to describe a growing number of "specialized" antibiotics. These provide the best means of destroying pathogenic bacteria which range all the way from large protozoa through gram-negative and gram-positive bacteria to certain viruses at the far end of the spectrum.

But beyond the spectrum lurk pathogenic fungi. Aggressive infections often require intensive broad spectrum antibiotic attack. It becomes more apparent every day that fungal superinfections may occur during or following a course of such therapy.^{1,2} Long term debilitating disease, diabetes, pregnancy, corticosteroid therapy, and other causes may predispose to such fungal infections^{1,3,4} as iatrogenic moniliasis. These facts complicate the administration of antibiotics.

Mysteclin-V controls both — infection and superinfection. Mysteclin-V makes a telling assault on bacterial infections and, in addition, prevents the potentially dangerous monilial overgrowth.^{2,5-8} Mysteclin-V is a combination of the phosphate complex of tetracycline — for reliable control of most infections encountered in daily practice — and Mycostatin, the first safe antifungal antibiotic.

Case history after case history marked "recovered" provides clinical evidence of the special merit of this advance in specially designed antibiotics. When you prescribe Mysteclin-V, you provide "broad therapy" with extra protection that extends beyond the spectrum of ordinary antibiotics.

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condition. Naturally, the physician's the one who has to advise when the routine billing should be delayed as the management service has only one slogan: Get out the billings!

Admittedly, the physician is entitled to his fee and he should get it promptly. On the other hand, trying to get it too promptly is one sure way of shattering the respect and confidence of patients.

USE OF PEP PILLS IN ATHLETICS BAD STUFF

The athletic coach who feeds his athletes amphetamine drugs to pep them up for competition and the physician who aids and abets him—they can only be secured legally on prescription—are playing with dynamite.

In a recent report, an AMA committee after a two year study emphatically condemned the practice as "inconsistent with the practice and ideals of sportsmanship" and pointed out that their repeated use "may be associated with harmful effect."

The committee said a "serious responsibility" rests on physicians to prescribe amphetamine drugs only on the basis of "definitive medical indications in individual patients." It pointed out that the drugs are legally obtainable only on prescription.

"The report warned that regular use of the drugs "may well lead . . . to habituation and indiscriminate use, thereby exposing the user to known effects of acute and chronic toxicity."

The survey made by the committee revealed that less than one per cent of the coaches polled had ever administered amphetamines.

We know of no cases in Ohio. If there have been any, they certainly have been few and far between.

Nevertheless, since the season of major sports activities is at hand, this warning about the injurious effects of the so-called pep pills is not untimely nor out of place.

SALEM HOSPITAL CUTS RATES, RAISES SALARIES

Attention all hospitals!

Hospitals, official magazine of the American Hospital Association, carried a story recently about how the Salem (Ohio) City Hospital reduced rates and raised the pay of employes all in the same breath, apparently without impairing services and without going into the red.

According to the article the economies made have been in food service, laundry, organized purchasing, standardization of supplies, use of disposable supplies and equipment, installation

of labor saving equipment and more effective utilization of nursing personnel and other employees.

In our opinion, there are quite a few hospitals which should send for the magic formula without delay.

FEES FOR PHONE CALLS THE BUNK

According to the *AMA News*, some physicians have been experimenting with charging patients for each telephone call. They say it's to discourage unnecessary inquiries and provide additional income.

In our opinion, such physicians could have used their time to better advantage. For example, they might have used the same amount of time in discussing finances and fees with some of their patients who are hard-pressed to make their budget meet all necessities.

As the *News* pointed out: "A doctor's fee for home and office calls should be gauged sufficiently high to compensate for occasional services, such as telephone conversations, medical reports, and filling out insurance forms."

Too many people today think that too many physicians are concerned about nothing but fees or how to increase them. This isn't the case but stupid ideas like the one described here aren't helping to get people to thinking the right way.

HOW ABOUT A "HEALTH CAREERS DAY" IN YOUR COMMUNITY?

Many benefits would accrue to its members and the medical profession as a whole if each County Medical Society would take an active part in a "Health Careers Day" in the schools of the area.

Such programs help in the necessary job of recruiting personnel for medical and para-medical positions. Moreover, they give members of the medical profession a splendid opportunity to give youngsters facts and good advice about physicians and the profession of medicine.

Members of the woman's auxiliary could be used on setting up and following through on the details.

If there is enough interest among physicians in a worthy project of this kind, the County Society officers probably will be willing to take it on.

Societies which have a program underway, or contemplate having one, can get help from the AMA Public Relations Department in the form of pamphlets and exhibits and from the Columbus Office of the OSMA.

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SQUIBB HYDROXYPROGESTERONE CAPROATE

DELALUTIN offers these advantages over other progestational agents:

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DELALUTIN is also potent and safe therapy for: threatened abortion; postpartum after-pains; amenorrhea, primary and secondary; dysfunctional uterine bleeding not associated with genital malignancy; infertility with inadequate corpus luteum function; production of secretory endometrium and desquamation during estrogen therapy; premenstrual tension; dysmenorrhea; cyclomastopathy, mastodynia, adenosis and chronic cystic mastitis.

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Delalutin is available in vials of 2 and 10 cc., each containing 125 mg. of hydroxyprogesterone caproate in sesame oil, and benzyl benzoate.

Each of these healthy, normal babies was born by a mother with a documented previous history of true habitual abortion, who was treated during her most recent pregnancy with DELALUTIN.



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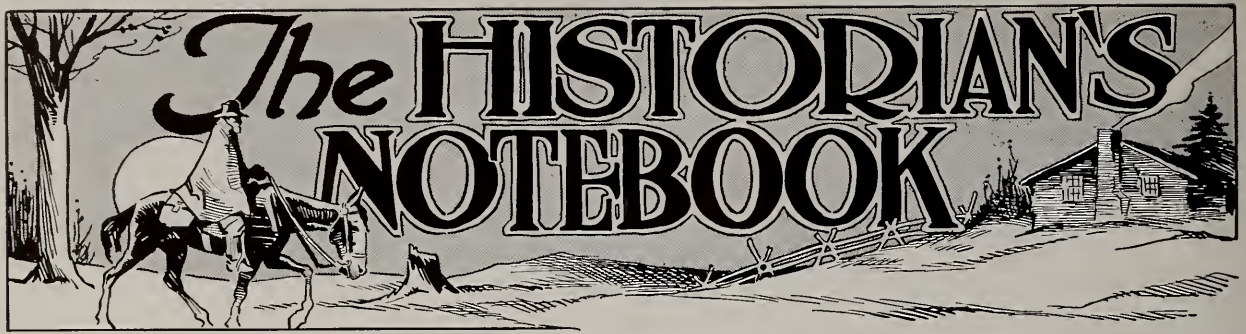
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A Short History of Medicine and the Physicians Of Delaware County, Ohio

M. S. CHERINGTON, M. D.

PART III

(Concluded from September Issue.)

DR. ELEAZER COPELAND, the sixth to locate in the county, came during the same year as Dr. Moulton—1819. Also from Vermont, he located in Zoar, now called Galena, and to our knowledge, was the first doctor there. He was a shoemaker by trade and studied general subjects and medicine while plying his trade. All will admit he was a self-made man.

While working at the bench he committed to memory Murray's English Grammar in two weeks' time. Other texts followed in rapid succession and then he prepared himself for schoolteaching. While teaching school he studied Greek and Latin, which he mastered without an instructor, and soon became a perfect translator of both languages. He took up the study of medicine in the same manner and became a careful, skillful and excellent physician.

District Censor

Dr. Copeland was highly esteemed by all of his professional brethren. He held the position of censor of the Sixth and afterwards of the Eleventh Medical District of Ohio, composed of the counties of Franklin, Marion, Crawford and Delaware. He was accidentally drowned in Big Walnut Creek, near Galena, in 1834. As a wise counsellor, a superior physician, a mature scholar and a useful citizen, his loss was deeply felt in all circles.

DR. ROYAL N. POWERS, the seventh doctor to come to the county, located in Delaware in 1820. It is not known where he came from or where

The Author

- Dr. Cherington, Delaware, is a member of the staff of Jane M. Case Hospital.

he went from here. His conduct was not appreciated in the community and he was compelled to leave unceremoniously, on a rail, carried by several citizens, and others who accompanied him a short distance from the town, as a lasting remembrance of their good will.

DR. ALPHEUS BIGELOW, the eighth doctor, settled in Zoar, now Galena, in 1820—perhaps a year after Dr. Copeland. He was a brother of the celebrated evangelist, the Reverend Russell Bigelow, of the Methodist Church. The doctor, like his brother, was a self-educated man. Both men possessed great energy of character, as well as strong intellect. He possessed a mind of his own and excellent judgment. Dr. Bigelow was not a regular graduate, like many others in the county, and he seldom evinced any disposition to cultivate an intimacy with any school of medicine, but he was a very skillful physician. He died in 1850 and had been in practice in one place, longer than any other physician at that time in the county.

James Harvey Hills

DR. JAMES HARVEY HILLS, probably the ninth physician to come to Delaware, was raised at Farmington, Connecticut, and educated at Yale College. He gained his early medical knowledge

Presented before the Delaware County Historical Society April 27, 1959.

in the office of his brother-in-law, Dr. Eli Todd, out East, who was one of the most highly educated men in the profession of his time. After practicing at his home place Dr. Hills determined to go west and so set out for Ohio. He is known to have settled first at Ravenna, Ohio, but in due time located at Worthington, in 1808. Here he soon grew in much favor and was called for, far and near, to attend the afflicted. He made frequent trips to Berkshire and Delaware and was for a time the only doctor in the area besides Dr. Lamb.

At this point, I want to speak of a bit of sidelight history. Soon after locating in Worthington Dr. Hills became affiliated with the New England Lodge, F. & A. M. He took the Fellow Craft degree on April 24, 1809, while Col. James Kilbourne was Worshipful Master and Ezra Griswold was Secretary; Samuel Sloper, the father-in-law of Dr. Lamb, was Tyler and William Little was a member. I mention this for in a few years he located in Delaware and found them all to then be residents there. Dr. Hills was raised to the sublime degree of a Master Mason, May 10, 1810. He served in different chairs and soon he joined Horab Chapter of Royal Select Masters.

Hardships of Military Campaign

While living in Worthington Dr. Hills was found ready for duty when the War of 1812 began and he was made Surgeon of the Sixth Regiment of regulars, and marched with General Harrison through the forests of central Ohio to Fort Defiance on the Maumee River near Toledo. While there he became seriously ill and a scout was sent back to tell his wife of his illness. She at once had her faithful riding mare saddled and prepared for the long and dangerous journey of 130 miles, through the forests and swollen streams amidst dangers and death from the red men and English scouts, to her sick and possibly dying husband. Finally, safely reaching the camp she ministered to him and others there until Dr. Hills had recovered and they could return to Worthington and to their family.

In 1818 they left there and moved to Darby Plains, in Logan County, and lived at West Liberty for four years, when they came to Delaware, in 1822. Here they found a town of about 40 houses and 250 people enjoying life. Among them were the Kilbournes, Littles, Byxbes, Walkers, Lambs, Hayes, and Sydney Moore with all of whom he had fraternized at Worthington. During this year the Reverend Joseph Hughes died from the plague. Through the years many of the town's finest men were taken by this same plague, or Milk Sickness, among them being Mr.

Hayes, the father of United States President Rutherford B. Hayes; J. B. Andrews, the father of Hon. Charles Sweetzer; and in 1830 Dr. James H. Hills.

Dr. Hills had married Miss Beulah Andrews, back East and was the father of a large family. There were three sons named Ralph, two having died in infancy, and the third who followed in the footsteps of his father and attained great prominence. The other sons were Reuben E., Chauncey Harvey, Darwin T., and James H. The daughters were Eleanora, Mary Jane, Rachel, and Mary. All of the children left their imprint for much good on the community in which they lived.

DR. GEORGE M. SMITH, of New Hampshire, came to Delaware in 1826 and formed a partnership with Dr. James Hills. He was a thorough anatomist. He was compelled to leave his native State for exhuming a human body for the purpose of study. After several years in Delaware his abode was discovered by the authorities in the East. He then went to Mississippi where he married a woman of wealth. In a few years he returned north on a visit and died of cholera. Dr. Smith is particularly remembered because he was the first one to introduce quinine in the county for the treatment of chills and fever, and malaria. This was in 1826.

DR. W. W. MILLER, given to us by Virginia in 1827, first practiced in famed Worthington briefly, and then came to Delaware. While he was well trained, he did not seem to do well here and moved shortly to Columbus and after that to Missouri. He was a brother-in-law of United States President, John Tyler.

Ralph Hills

DR. RALPH HILLS began practice in Delaware in 1830. He was the son of Dr. James H. Hills, of whom we have spoken and who began his work in Worthington in 1808, coming to Delaware in 1822. Dr. Ralph Hills was born in Worthington in 1810 and was 12 years old when he came to Delaware, with his parents. In the first years of his life he was given the most careful training, under the best teachers of his time.

At the age of 17 Ralph took up the study of medicine under his father. He went to Cincinnati in 1828 to attend medical lectures. He showed great aptness and did thorough work in all branches, but he devoted himself especially to the study of the nervous system. In 1830, before his graduation, he was compelled to return home on account of the death of his father. The

faculty of the college granted him an honorary degree to practice medicine.

National Fame

The reputation of Dr. Ralph Hills as a successful physician and surgeon became known far and near. He was a great student in many branches of knowledge and he was employed to deliver a series of lectures on astronomy, and traveled with the Russell's Great Planitarium for two years. He was a great thinker on many scientific subjects, other than those pertaining to medicine. As a writer, none questioned his ability. His judgment and calculations upon matters of business were almost unerring.

After a few years of hard practice, at the earnest request of his uncle, Dr. Eli Todd, who had charge of a large hospital for the insane at Hartford, Conn., Dr. Hills went there to assist in the work and to study nervous disorders. This study and knowledge under Dr. Todd, laid the foundation for his great work and usefulness in after years.

It was in Dr. Hills' parlor and through his influence, that the idea originated and developed into the Ohio Wesleyan Female College. Through him and his intimate friends the Ohio Wesleyan University's future greatness was assured. In 1854 he established and edited the first weekly medical journal, published in the West.

Headed Columbus Asylum

After two years of editorial work and publishing he was called to the superintendency of the Central Ohio Lunatic Asylum at Columbus, Ohio. For more than eight years he labored in the new field, going to Europe to study all of the new advancements in the great field of nervous diseases. His work of advancement for the unfortunate made his name nationally prominent. He was called in 1862 to plan, superintend, and build the largest state asylum in the United States at Weston, West Virginia. In 1871 he completed the task and established a new era in this branch of medical science, which will last for ages.

Dr. Hills then returned to his home in Delaware and retired from active life. Possessing an active brain and a strong physique for a man of his age and labors, it was not intended that he should be idle. He then designed, patented and built several fireproof houses which added to his fame. He also organized, among the physicians, a class to study and investigate medical and other scientific subjects.

It was said by Dr. Clouston, of England, that "Dr. Hills was a third of a century in advance of his time in the treatment and care of the

insane. He has unlocked the strong, iron-barred doors and has cut the shackles from the ankles and wrists of the unfortunate insane and has turned them loose to enjoy the playgrounds and the beautiful sunshine, and has given them other equally beneficial entertainment."

Ohio state authorities soon sought out Delaware's great thinker and tendered him the position of head of the Girls' Industrial Home in this County. Again he went to work to benefit humanity. In the very midst of his active work he was summoned by the great Master, whom he had always served in a conscientious manner, to His realm. Stricken with a cerebral hemorrhage, in a few days it was all over and his work was done, October 1879. In a short time his widow followed, leaving a daughter.

Others That Followed

The foregoing is as much as we can cover now, bringing us up to about 1850, but following are the names of other physicians that through the years have been here some time, were popular and well regarded by the physicians and the citizens:

Dr. M. Gerhard came here in 1840, married the granddaughter of Dr. Reuben Lamb, and died in 1868; Musician—played many instruments. He owned the first piano ever in Delaware and it was frequently borrowed by Ohio Wesleyan University for commencement exercises. He was the first in the county to use chloroform as a general anesthetic for surgery and the first to use antiseptics in open wounds.

Dr. Abram Blymer came in 1841 and died in 1882. He was one of our best physicians and a great and respected leader in the community.

Dr. T. B. Williams came in 1849; Was in the Civil War as a Surgeon; Served long on the School Board and was in the Ohio Legislature. Died in 1879.

Included, also, were Dr. John Little; Dr. Joseph H. Van Deman; Dr. Joseph McCann; Dr. E. H. Hyatt; Dr. W. T. Constant; Dr. A. E. Westbrook, Ashley; Dr. B. W. Hedges, and Dr. W. N. Vogt.

Antique Pharmacy Collection

Chas. Pfizer & Co., Inc., has presented a rare collection of 18th and 19th century pharmacy equipment, glassware and ceramic jars to the recently-restored McDowell Apothecary in Danville, Kentucky. The shrine honoring Dr. Ephraim McDowell, pioneer surgeon who was the first to perform successfully a major abdominal operation, has been restored by the Kentucky State Medical Association and the Kentucky Pharmaceutical Association. Dr. McDowell opened the Apothecary in 1795 when he began to practice in Danville.

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PERRY R. AYRES, M. D., *Editor*

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Managing Editor — Bus. Mgr.

R. GORDON MOORE,
Asst. Managing Editor

The Shoulder - Hand Syndrome*

FRANK H. MAYFIELD, M.D., and RICHARD E. NEWQUIST, Capt. USAF MC**

IN 1897 Osler described disability of the shoulder occurring in some patients after coronary occlusions.⁶ In the subsequent 62 years there has grown a body of literature on the "Shoulder-Hand Syndrome," bringing into the subject a variety of clinical and pathological situations and tempting the reader to conclude that the syndrome, as an entity, exists only in print. Facetiously expressed, the shoulder and hand are constants, but the syndrome, particularly as concerns etiology, is a variable. The picture visualized by the clinician is determined by his own field of special interest.

To the physician, the Shoulder-Hand Syndrome is a painful ankylosis of the shoulder, often associated with vasomotor dystrophy of the extremity following coronary occlusion. The orthopedist is apt to visualize in his mind's eye lesions that are primarily in the bursa or pericapsular tissues of the shoulder. The neurosurgeon includes causalgia from trauma to the peripheral nerve trunk or encroachment on the roots of the brachial plexus by osteoarthritic spurs in the cervical spine, trauma to the cervical discs and even cerebral vascular accidents as potential causes of this syndrome. The vascular surgeon will find disturbances of blood flow, either arterial or venous, with swelling of the arm or ankylosis of the shoulder, as the more common cause in his experience. To the general surgeon, the Shoulder-Hand Syndrome is most often encountered as a complication of mastectomy.

*Read before the Joint Meeting of the General Practice, Internal Medicine and Surgery Sessions, Ohio State Medical Association, April 22, 1959.

**The contents of this article are the personal views of the authors and are not to be construed as statement of official Air Force policy nor as Air Force indorsement of any commercial product described.

The Authors

- Dr. Mayfield, Cincinnati, is Chairman, Department of Neurosurgery, Christ Hospital and Good Samaritan Hospital.
- Capt. Newquist, Cincinnati, is Resident in Neurological Surgery assigned to University of Cincinnati Hospitals.

It is the intent of this presentation to review briefly certain fundamentals of the anatomy, pathology and pathological physiology peculiar to the shoulder and to recall the principles of certain pain mechanisms arising from diseased or injured nerves. By this means it is hoped that a rational program for differential diagnosis, treatment and prognosis of the Shoulder-Hand Syndrome may be drawn.

Physiology

Unlike the hip joint, the shoulder joint is not a weight-bearing one. Instead, it is a suspended pivot around which a heavy, pendulous upper extremity is suspended, subjected constantly to the pull of gravity and held together only by the soft tissue capsule and its musculo-tendinous cuff. Its only bony connection with the remainder of the skeleton is at the sternoclavicular joint, the clavicle serving as a boom to which many structures are attached and, at the same time, serving as a prop to keep the shoulder away from the spinal column.² The shoulder, however, is also the cross-roads to the arm for all neurovascular connections

between the brain, the spinal cord and the major viscera, including the heart.³ (Fig. 1.)

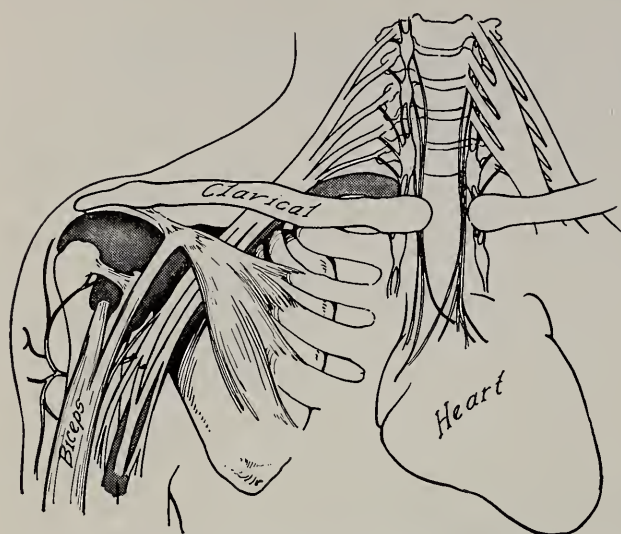


FIG. 1. Anatomical diagram showing the major anatomical structures of the shoulder in relation to the heart and the capsule of the shoulder joint.

As one ages or becomes enfeebled for any other cause, the skeletal musculature deteriorates and degeneration of collagens begins. In the shoulder, as one ages, the humeral head actually begins to recede from the glenoid fossa. If hypertrophic spurs are encroaching upon the nerve roots of the brachial plexus, it is probable that the muscles across the shoulder are also wasting, the tendency of the shoulder joint to separate is further speeded or enhanced, and the shoulder accordingly becomes more vulnerable. Even in the absence of any major disease of the heart or the peripheral nerve trunks, the shoulder under these circumstances tends to become painful, but the pain does not arise from a weight-bearing surface but from the soft tissues of the musculo-tendinous cuff of the shoulder joint and, of course, from the bursa about the shoulder.

It has been shown experimentally, both in animals and in the human, that prolonged bombardment of any part with painful stimuli can and will induce edema of the tissues of the part supplied, and it is also well known that there is a constant interplay of impulses between the fibers of any nerve. If the myelin sheath of a nerve becomes fragmented as the result of trauma, then this interplay amounts to a massive short-circuiting, and the part supplied by the nerve is then bombarded by stimuli that are painful and are capable of inducing major tissue changes in the form of edema.³ As the pain continues, and it may be referred in reverse in the case of the shoulder, the tissues of the shoulder become swollen, inflamed and painful, and following upon this one is apt to note disturbances in blood flow and in sweat and

pseudomotor activity of the arm. If the shunt or short-circuit is massive, whether occurring in the periphery, as is frequent with fractures of long bones or injury to the great nerves, or whether the lesion occurs in the heart, with damage to the sympathetic supply to the arm, the ultimate result is the same.

If one adds to these factors the disabling effects of dependency and disuse that is the usual lot of the bedridden patient, the final conditions for the making of the Shoulder-Hand Syndrome are met. It is to be reemphasized that the end-result is the same, whether the cause is in the heart or elsewhere. The patient will develop capsulitis, calcific tendinitis, calcific deposits in the subdeltoid or subacromial bursa, bicipital tendinitis or even actual spontaneous rupture of the rotator cuff of the shoulder.

Pathology

Variations in the evolution of the clinical picture are many, but one may describe the events in a hypothetical "typical" case thus: From 3 to 16 weeks after a myocardial infarction, and often during recovery, a patient may begin to notice the insidious onset of pain in elevating the shoulder, usually the left. Shortly thereafter, he may complain of swelling, pain and stiffness in the hand and all fingers. The skin of the hand becomes smooth and a dusky pink. The grip becomes weak and the hand slightly warm to the touch. The shoulder is exquisitely tender to the touch and the patient resists any passive or active movement of the extremity. X-ray at this time is usually negative.

If untreated or unresponsive to treatment, the acute pain in the shoulder subsides in two to three months, but the shoulder becomes stiff and the range of motion limited. The hand becomes cool and cyanotic and the palmar fascia thickens. In place of edema of the hand, there is substituted early atrophy of the subcutaneous tissue and intrinsic muscles. The hand and elbow assume a flexion posture. X-ray at this time may show diffuse or spotty osteoporosis of the hand and humerus.

If totally refractory to treatment, in 6 to 12 months after the onset of symptoms, the shoulder joint will have become "frozen," the musculature of the shoulder girdle atrophied and the hand flexed, contracted and atrophied. The skin of the extremity will be cool, smooth and blanched. X-ray may show severe osteoporosis, calcification in the tendons and bursae of the shoulder and possibly even subluxation.

Diagnosis in the early stages may be difficult. Onset may be sudden but may be so gradual that the patient cannot, in retrospect, after irreversible

changes have taken place, remember the early events. Laboratory studies are not helpful. Although it is true that many cases are idiopathic, diagnosis and management will be most successful if the syndrome is thought of as a complication of some underlying disorder and that disease diagnosed and properly treated. It must be remembered that in addition to myocardial infarction, any disease of the cervical or upper thoracic spine, soft tissues of the neck, shoulder joint, arm, hand or even the cerebrum may give rise to the clinical picture.

Incidence of the syndrome following myocardial infarction is in the order of 10 to 20 per cent. Ernstene and Kinell in 1940 noted the occurrence of disabling shoulder pain in 17 out of 133 consecutive coronary occlusions.¹ In 1943 Johnson reported that 39 of 178 cases of myocardial infarction showed trophic hand changes and 34 of these also had shoulder disability.⁴ It is our experience that the incidence in cervical disc disease is less than 5 per cent. On the other hand, nearly 100 per cent of cases of cerebral thrombosis with hemiplegia will develop some manifestation of the picture. The incidence in bursitis, calcific tendinitis, hand and arm trauma is more difficult to assess because of the manifestations of the local lesions themselves.

Treatment

Treatment of the Shoulder-Hand Syndrome must be begun early to be effective. The most important step is prevention when possible. All who have dealt with surgical diseases of the upper extremities, including trauma, have recognized that elevation of the part and passive mobilization is essential to good healing and also to the prevention of ankylosis about the shoulder. It would appear that the severe pain, as well as the terrific anxiety that follows immediately upon a coronary occlusion, leads to immobilization that sets up tissue changes in the shoulder within the first few days. Passive exercise of the shoulder and elevation of the part from the outset and control of the pain by medication should avoid this complication. On the other hand, if these precautions have not been taken, or if the syndrome develops despite the most satisfactory therapeutic regime, elevation of the part should be undertaken nevertheless and mild passive exercises, as pain will permit, also carried out.

For the causalgic and vasomotor symptoms which may secondarily develop, procaine blockade of the sympathetic chain or long-acting ganglionic blockades such as tetraethylammonium salts, Etamon® or Priscoline® should be used.^{5,9} In the experience of the senior author, sympathectomy is rarely if ever necessary for control of pain in the

Shoulder-Hand Syndrome, although sympathectomy for coronary pain is frequently of value.

Steroid therapy has been tried with some success by Russek et al.,⁷ but we have had no experience with this.

If the etiologic mechanism is disc disease or osteoarthritis of the cervical spine, cervical traction, collars or even cervical laminectomy may be necessary. Local procaine injections of the painful site in the shoulder or hand have had equivocal results, as might be expected, since one is ordinarily dealing with referred pain. On the other hand, appropriate treatment of secondary sites of disease about the shoulder joint, such as the bicipital tendon or the acromion bursa is recommended. Active physical therapy routines should be withheld during the acute, painful, edematous phase but are of definite benefit later in preventing contractures and secondary disuse atrophy.

Results of treatment are difficult to evaluate, since in many cases the disease is mild and self-limiting, without treatment, whereas in others, in spite of the most aggressive program, the syndrome progresses relentlessly. However, with early diagnosis and resourceful use of all the therapeutic measures at hand, resolution of the syndrome may be expected in the majority of cases.

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Giant Ulcers of the Stomach

The difficulties in arriving at a correct diagnosis of large gastric ulcer by clinical, x-ray, gastroscopic, and operative studies including gastrotomy for direct visualization of the ulcer emphasize the importance of making a correct diagnosis on the basis of histologic study only. Though usually benign, they do not respond to medical management, and surgery is the treatment of choice.—Isidore Cohn, Jr., M. D., Jack Sartin, M. D., and Perry Sudduth, M. D., New Orleans: *Am. J. Gastroenterology*, 31:134, August, 1959.

Duodenal Ulcer: Some Observations on Pathogenesis

C. JOSEPH DELOR, M. D., and FLOYD BEMAN, M. D.

Introduction

TEN PER CENT of the population, according to Sara Jordan,³⁰ will suffer from peptic ulcer at some time in their life. The ratio of men to women is 3.5 to 1. The etiology of ulcer has not been proven but certain facts are generally accepted concerning the development of the disease. Abnormal gastric secretion characterized by hypersecretion, hyperchlorhydria, and elevated pepsinogen levels^{9, 12, 13, 16, 19, 25, 27, 28, 49} is a consistent, and probably the most important, finding in duodenal ulcer. Also concerned in the pathogenesis of this disease are heredity,^{5, 40, 42, 45, 49} endocrinopathies,^{54, 60, 62} psychic disturbances,⁴⁹ intracranial lesions,⁴⁶ burns,^{18, 26} stress,^{3, 53} habits and drugs.^{9, 11, 15, 20, 34, 36}

While there are many common denominators for peptic ulceration of the esophagus, stomach, duodenum, jejunum and ileum, there are sufficient variants to consider these sites separately because the secretory, hormonal and other precipitating causes differ with the locale of the lesion. It is the purpose of this paper to discuss some of these problems with illustrations as they apply to duodenal ulcer.

Gastric Secretions

Normally man secretes a potent fasting acid-gastric juice containing up to .5 per cent hydrochloric acid,⁴ 350-600 mcg. tyrosine units of pepsinogen per ml.,^{19, 25} mucin (mucoprotein), rennin and lipase and .14 per cent of inorganic substances (sodium, potassium, magnesium and calcium).⁴ This secretion is divided into the cephalic, gastric and intestinal phases, under control of neurogenic and hormonal mechanisms.

The cephalic component results from stimuli from various cerebral centers which are transmitted to the parietal cells of the stomach by the vagus nerve. This may be brought about by a conditioned reflex initiated by any number of stimuli, for example, the odor of food. Changes in the plasma constituents, such as insulin induced hypoglycemia, will produce a similar neurogenic stimulation. It is estimated that 80 per cent of gastric secretion is brought about through this route.¹² Another 15 per cent is the result of production of the gastric hormone (gastrin) produced by the cells in the antrum of the stomach as a result of a variety of stimuli. The more important

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stimulants would be mechanical distention of the antrum and protein foods. Perhaps 5 per cent of secretion results from hormonal stimuli from the intestine. The volume and composition of gastric juice produced in any given time has been the subject of voluminous investigations in man and animals.

Patients with duodenal ulcer, in addition to having increased secretions, also respond up to 3 or 4 times more intensely to stimulation. Since almost anything will stimulate gastric secretion, it becomes necessary in testing any substance to ascertain the basal secretory rate in any given individual in order to evaluate the test substance (Kirsner).³⁴

The collection of gastric juice has resolved itself into the 12 hour nocturnal specimen and the fractional one³⁷ or two hour⁴⁴ method. It has been repeatedly demonstrated that the volume and acid content of the 12 hour nocturnal specimen^{12, 22} is markedly increased in duodenal ulcer. The normal 12 hour nocturnal volume has been stated to be approximately 560 cc. or less with a maximum of 18 to 20 mEq. of free hydrochloric acid.¹² In duodenal ulcer these figures are often trebled while in gastric ulcer they are usually normal or less.

The one and two hour gastric analysis,^{17, 37, 44, 52} likewise has been the subject of many investigations. The essential diagnostic feature of these tests is the demonstration of a sustained secretion in response to a test meal. An example of this type of response is that by Roth⁴⁴ using caffeine. This stimulus produces a sustained hyperchlorhydria of 50 mEq. per liter or more at the end of two hours in almost all patients with duodenal ulcer. Littman et al.³⁷ recommend a single gastric

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aspiration one and one-half hours after swallowing .5 Gm. of caffeine sodium benzoate in 200 cc. of distilled water, with any final result above 25 mEq. per liter being diagnostic of hyperchlorhydria and/or duodenal ulcer in those patients suspected of having this disease.

Food as a Secretory Stimulant

All food and drink will stimulate the stomach to secrete, but such items as coffee,^{37,44} tea,^{39,57} alcohol, seasonings,⁴⁸ drugs,^{15,20,34} and chemicals¹⁷ are more potent than others. Patients with duodenal ulcer show an exaggerated response. Alcohol, carbohydrate, caffeine, tea, histamine and protein test-meals have been the stand-by of the gastric analyst for years. The effect of tea has been debated,⁵⁷ but reliable chemical studies³⁹ substantiate that the main xanthine in tea is caffeine.

Attention⁵¹ has been directed toward the stimulating properties of such foods as orange juice. It has been recognized that some people do not tolerate oranges, particularly those with hypersecretion. Both fresh and frozen orange juice are capable of this effect. One study⁵¹ points out that orange juice did not apparently delay healing in peptic ulcer, it being postulated that because of vitamin C, healing is encouraged. Seasonings⁴⁸ such as black pepper, chili pepper, cloves, mustard seed and nutmeg have been shown to produce heartburn, belching and nausea in active ulcer patients, but again, healing time was unaffected.

Drugs and Gastric Secretions

Caffeine is an important ingredient of drug preparations (P. A. C. tablets, Cafergot,[®] caffeine sodium benzoate). It also has long been thought that salicylates^{15,20} have a direct irritating effect on the gastric mucosa. Peptic ulceration in the older individual, particularly those with gastric ulcer, has been correlated with the excessive use

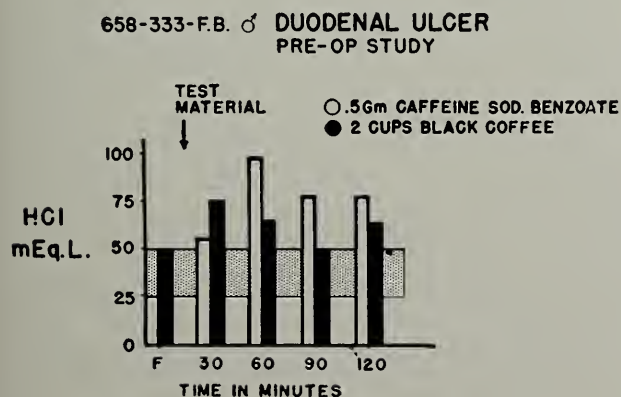


FIG. 1. Preoperative study of the effect of caffeine and coffee as a secretory stimulant in a patient with proven duodenal ulcer.

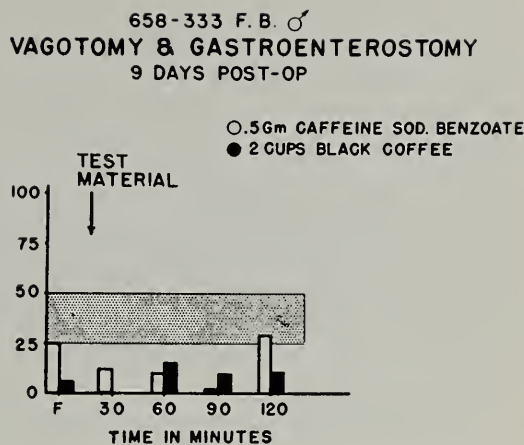


FIG. 2. Postoperative study on patient depicted in figure 1 showing the inability of caffeine to stimulate gastric secretion after vagotomy, suggesting that the site of action is cephalic.

of these compounds for analgesia. Phenylbutazone (Butazolidin[®])³³ and Rauwolfia^{11,36,47} and its derivatives increase acid gastric secretions. A curious fallacy is the use of peppermint to flavor antacid preparations. The amount of peppermint

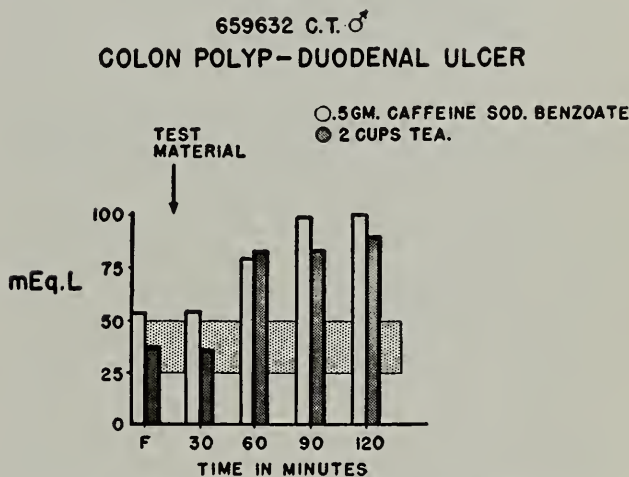


FIG. 3. The effect of tea as a secretory stimulant is apparently dependent on its caffeine content.

necessary to stimulate the stomach is small, 2 drops in 100 cc. of water producing a good secretory response.

The inhibition of gastric acid secretion in dogs by the precursor of serotonin, 5-hydroxytryptophan, has been described.²³ It has been postulated that this is a local inhibitory action and it does not inhibit histamine induced hypersecretion and hyperchlorhydria. Antihistamines also inhibit⁴³ gastric secretion induced by stimulation of the antrum. However, they do not inhibit acid secretion induced by insulin hypoglycemia and histamine. Ragins et al.⁴³ explain this on a toxic effect directly on the gastric mucosa by the antihistamine, rather than a systemic effect which would be the case in insulin-hypoglycemic (vagal) hyperchlor-

hydria or histamine (hormonal, antrum). Radiation has been used for a number of years by Palmer, Kirsner and others^{31,35} to produce prolonged periods of inhibition on acid gastric secretion.

The effect of smoking^{6,7,8,29,50} on gastric secretions has been a potent topic with some maintaining tobacco increases acid gastric secretions while others do not agree with this. As might be expected (?) there appears to be a higher incidence of smokers in ulcer disease than in the non-

tion. Their role in therapy is limited to that particular aspect.

Hormones and Gastric Secretions

Early reports suggested that ACTH and corticosteroids stimulated gastric secretion and predisposed to peptic ulceration.^{32,61} Subsequent work from separate investigators^{10,14,24,38,58} failed to corroborate these conclusions. Whether these hormones produce hypersecretion and/or hyperchlorhydria, forms the basis for the debate on the pituitary-adrenal axis theory of Gray²¹ which postulates that hormonal effects are mediated through the antrum.

However, the incidence of peptic-ulceration following ACTH and corticosteroid therapy does not

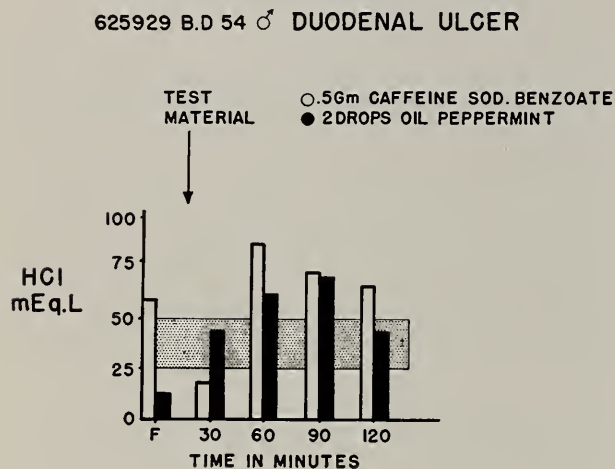


FIG. 4. Oil of peppermint (2 drops) dissolved in 200 cc. of distilled water produced a secretory response very similar to that achieved with caffeine.

ulcer populace. Furthermore, the rate of healing and the success of treatment is enhanced when the patient stops smoking. It probably can be said that smoking "has an adverse effect on ulcer and contributes to its clinical severity" (F. Avery Jones).²⁹

Anticholinergic drugs are vagal suppressants and therefore only affect the cephalic phase of secre-

PHASES OF GASTRIC SECRETION

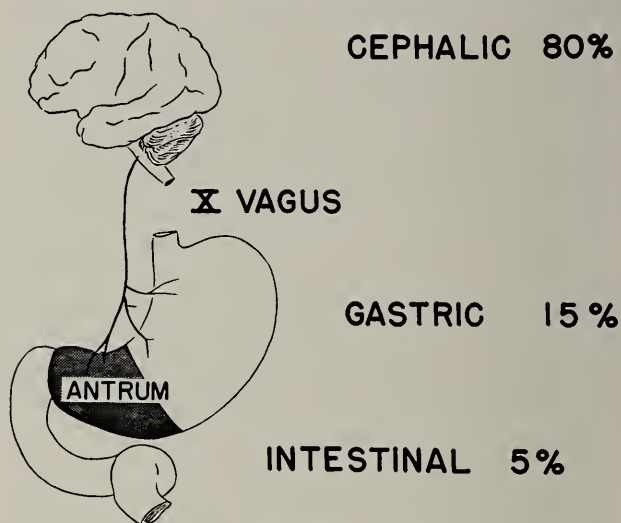


FIGURE 6

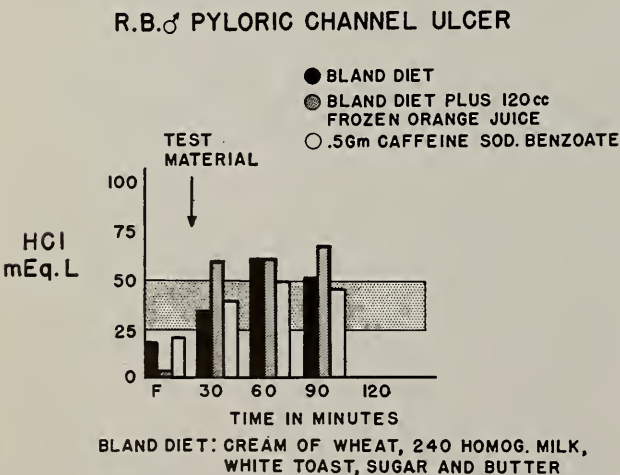


FIG. 5. The relative stimulating effect on gastric secretion following a conventional bland diet, then the effect of adding orange juice and finally, on a third determination, caffeine was added.

appear to be greater than that predicted for the general populace.³⁴ It has been shown by Hirschowitz et al.²⁴ that the increased uropepsin excretion is apparently due to the selective action of ACTH and corticosteroids on the kidney without any increase in serum pepsinogen. Unfavorable results have been reported in patients with gastric ulcer³² receiving ACTH and/or corticosteroids. Because of the undesirable effects from hormonal therapy (hypokalemia, hypernatremia, Cushinoid changes, psychotic tendency, potentiation of diabetes, dependency, anti-inflammatory effect and the questionable relationship of ACTH and corticosteroids to ulcerogenesis), the clinical use of these hormones in ulcer-prone people carries a definite risk quite aside from the question as to the direct relationship of hormones to ulcerogenesis, per se.

Primary peptic ulceration of the jejunum associated with islet cell tumors of the pancreas was described by Zollinger and Ellison.⁶⁰ Their original description of the syndrome bearing their

name does not include ulceration of the stomach or duodenum. Since then, however, ulceration of the duodenum and stomach, as well as the jejunum have been described with islet cell adenomas of the pancreas as well as from tumors of the pituitary, adrenal, thyroid and parathyroid glands, sometimes referred to as multiple adenomatosis (Wermer).^{54, 62}

Heredity and Peptic Ulceration

The role of heredity in the etiology and pathogenesis of duodenal ulcer has been postulated^{5, 42, 45, 49, 57} and attempts have been made to show the relationship of ulcer to ABO blood groups. Not all investigators are in accord.⁴⁰ On the assumption that 85 per cent of the population are either type O or type A, Buckwalter et al.⁵ present convincing evidence that there was statistically significant increases of type O with concomitant decreases in the three other blood types and that this same relationship held for hyperchlorhydria. This corroborated the British claim¹ that persons with type O are 35 per cent more likely to develop peptic ulceration than other blood types. Duodenal ulcer has been described in families,⁵⁷ but a true ulcer personality has never been universally accepted.^{2, 49}

Psyche, heredity and ulcer diathesis are intimate in their relationship to peptic ulcer, but they are not synonymous. The role of emotions, such as anger, hostility, rebellion, anxiety and panic is to increase gastric motility and secretions, even visible erythema of the gastric mucosa.^{3, 41, 53, 58, 59} It can be said that emotional storm in a predisposed individual is likely to cause hypersecretion and could contribute to the development of peptic ulceration. There does not appear to be a common denominator in personality types.^{24, 49}

Miscellaneous Facets of Ulcerogenesis

Burns^{18, 26} have been shown to bear a relationship in the causation of peptic ulceration (the Curling ulcer). The exact mechanism is not clear, but it is postulated to be due to hemoconcentration. The same may be said for peptic ulceration in patients with intracranial tumors which Rokitsansky described many years ago.²

These phenomena emphasize the local tissue susceptibility which must play a role in duodenal ulcer.

Summary and Conclusions

Increased gastric secretion with marked increases in hydrochloric acid pepsinogen levels have repeatedly been found in duodenal ulcer. All foods stimulate gastric secretion, however, some such as coffee, tea, seasonings and alcohol produce more profound sustained levels of hypersecretion. Many commonly prescribed drugs, such as salicylates,

caffeine, phenylbutazone, are ulcerogenic. The hormones have an equivocal effect on gastric juice, but appear to have an adverse effect in the presence of ulcer. Psyche and heredity play a role in the pathogenesis of this disease, as well as burns and intracranial lesions.

While the specific etiology is unknown, duodenal ulcer is more common in people with type O blood. There is no clear-cut evidence to support the existence of an ulcer personality. Some individuals are hypersecretors. Stress, emotional storm, burns, intracranial lesions and drugs may precipitate an ulcer in the presence of this hypersecretory state.

Acknowledgment: We gratefully acknowledge the assistance of Miss Joan Sharp of the Department of Dietetics, Ohio State University, Columbus, Ohio.

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Owing to limited space a reduced list of references is published here. Those interested may secure the complete bibliography of 62 references by writing to the authors.

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The Management of Early Prostatic Carcinoma

It is important to make a diagnosis of prostatic carcinoma as early as possible, because early treatment gives the best results whether radical prostatectomy is done or endocrine therapy used. Open perineal biopsy is the most accurate method of making a diagnosis. Perineal needle biopsy or the newer approach of transrectal needle biopsy is probably about 75 per cent accurate in making a diagnosis.

Ten-year survival with conservative therapy, as determined in a review of a series of cases, was 50 per cent—about the same as that following radical prostatectomy; but the patients with prostatectomy are clinically free of malignant disease whereas the former are not.

Radical prostatectomy is indicated in a few selected cases.

The results from endocrine therapy begun immediately after diagnosis are significantly better than those from delayed treatment. Orchiectomy and estrogens promise a little longer survival than estronogens alone.—Roger W. Barnes, M. D., and Delmont S. Emery, M. D., Los Angeles: *California Med.*, 91:57, August, 1959.

Hand-Schüller-Christian Disease with Long Survival — Report of a Case

ROY H. THOMPSON, M. D., DUANE N. TWEEDDALE, M. D.,
and I. H. EINSEL, M. D.

THE original Hand-Schüller-Christian triad consisted of skull defects, exophthalmos, and diabetes insipidus with a microscopic picture of a histiocytic granuloma. At present, through necessity it is more broadly defined to include instances in which multiple lesions are observed and in more than one system. Hand-Schüller-Christian disease is generally included in the group of conditions referred to as histiocytosis-X, which includes the related entities of eosinophilic granuloma and Letterer-Siwe disease.¹ According to present-day concepts Hand-Schüller-Christian disease rests midway between these in extent and severity.² Hand-Schüller-Christian disease may be conveniently separated from eosinophilic granuloma of bone by excluding from the latter, cases involving more than two bony lesions at the same time, with or without visceral involvement.³

It is occasionally difficult to separate these histiocytoses early in their course as one will note in the case reported herein. In fact, the present diagnosis of our case was only recognized after many years by correlating the histopathologic picture, clinical course, and roentgenographic features. When considering the aforementioned and the fact that the recognition and accurate delineation of Hand-Schüller-Christian disease and related entities has been a relatively recent phenomenon, our long term follow-up of a patient controlled by empiric means for the greater part of 19 years seems of special interest.

Case History

A 25 year old white female schoolteacher was first seen in 1940, complaining of recurring small tumors of the gums. She stated that a few months previously she had consulted her dentist because of a tender pea-sized lump on the gum of the left upper jaw. A dentist extracted two contiguous teeth without improvement. The lump increased in size and shortly thereafter an oral surgeon incised it — still without relief. Re-excision by an otolaryngologist was then resorted to. The pathological diagnosis of the specimen was "Epulis." That lesion did not recur, but a series of similar ones appeared, followed by a loosening of the teeth in the upper and later in the lower jaw. Facial bone views at the time showed "alveolar erosion." These tumors responded to moderate superficial radiation. A continuing series of episodes is recorded as follows.

In 1941, a small soft dusky raised vascular skin lesion appeared on the left cheek, which responded to superficial radiation.

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- Dr. Einsel, Cleveland, is Senior Surgeon, Woman's Hospital.

Again in December, 1942, an obstruction of the right nostril occurred with antral tenderness and x-ray evidence of right antral clouding, which responded to radiation (Fig. 1).

After a long interval, on August 31, 1946, a large right anterior cervical node was noted, removed for

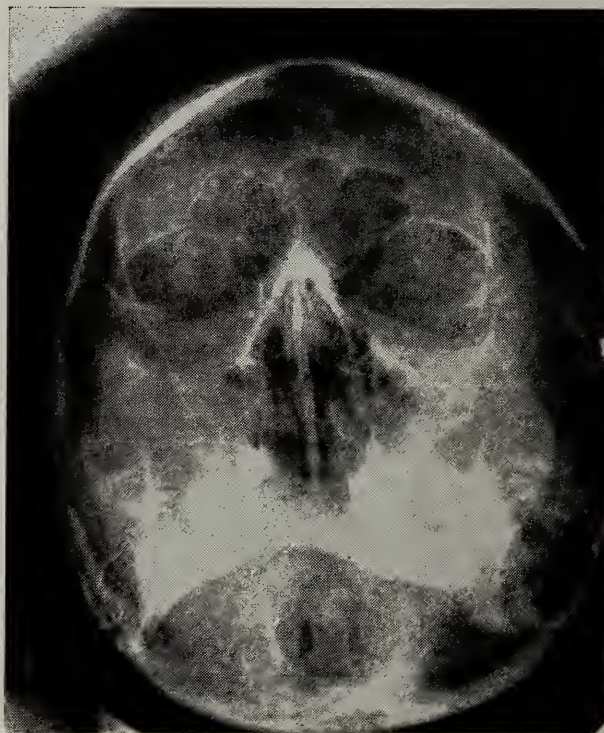


FIG. 1. Marked right antral clouding and partial clouding of the left antrum.

biopsy and the area irradiated with good response. The pathological report was "Epulis or Osteoclastoma."

On January 4, 1947, at age 32 the patient complained of voiding large amounts of colorless urine and of great thirst. There was no glycosuria. In addition, her menstrual periods became infrequent and scanty. Pelvic examination revealed uterine atrophy, typical of a

menopausal change. Shortly thereafter the patient ceased menstruating.

Again, on August 18, 1947, there was a recurrence of tumor of the gum at the site of the right lower incisor tooth. Superficial radiation was given and repeated again on December 30, 1947, with complete regression.

The patient then remained asymptomatic until October 6, 1951, when a recurrence occurred close to the right lower molar tooth and a small, soft, dusky skin lesion appeared near the external canthus of the right

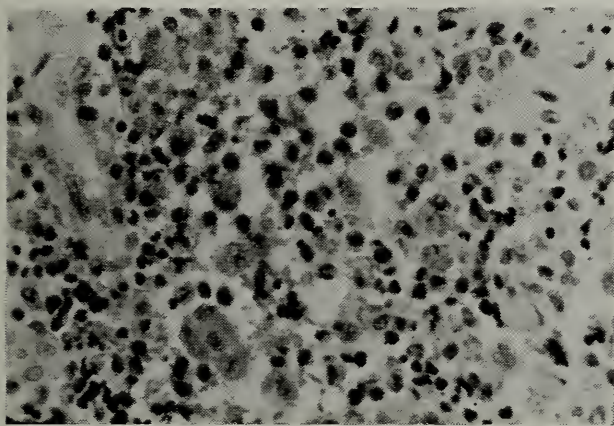


FIG. 2. Photomicrograph of tissue removed from the vertex of the calvarium in November, 1954. There is an admixture of giant cells, histiocytes, and eosinophils. The central zone of the giant cell at the far left is vacuolated. Giant cells were more prominent in other areas. Hematoxylin and Eosin X 430.

eye, both of which were controlled by radiation. In February, 1952, there were recurrences in the right maxillary and mandibular molar areas which responded to radiation. Again in December 1952, the right ant- rum was involved and x-ray therapy was given with improvement. In May, 1953, the right lower molar area was treated for recurrence. Radiodermatitis of the face was becoming evident after the numerous attempts to control the spread of the disease.

In February, 1954, the patient complained for the first time of bleeding from the nose and it was suspected

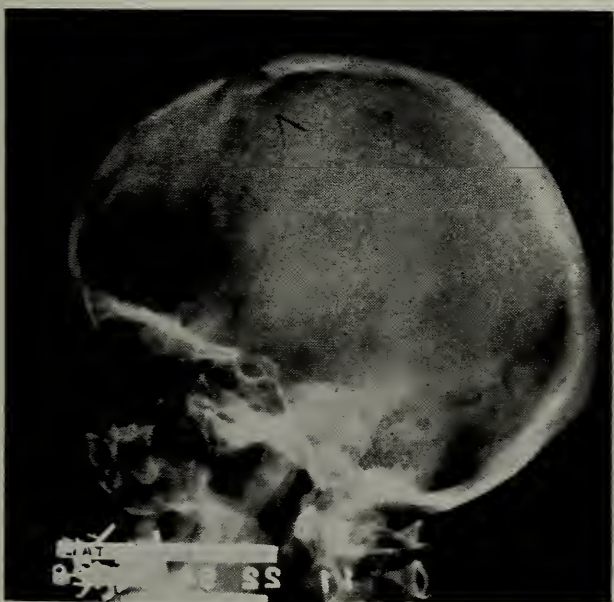


FIG. 3. View showing the sharply demarcated radiolucent area deep to the large superficial soft tissue scalp tumor. After treatment the inner table reossified.

that the tumor had invaded the right nasal septum. This also responded to radiation.

On October 30, 1954, dermatitis resembling erysipelas was found over the nose and left side of the face; it was cured by local ointments and antibiotics. Severe seborrhoeic dermatitis involving the entire scalp followed, which also cleared after conventional treatment.

In November, 1954, a tumor was noted in the soft tissues over the vertex of the calvarium about 1½ inches in diameter. It was surgically removed and was found to extend through the skull to the dura, (Fig. 3). Skull x-rays showed a 1.5 cm. radiolucency in the anterior fontanelle region. Excision and curettage was followed by radiation with complete arrest of the lesion.

In January, 1956, the patient developed a similar lesion in the region of the nutrient artery of the left humerus (Fig. 4) and an expanding lesion in the left tenth rib and left scapula. Her presenting symptoms

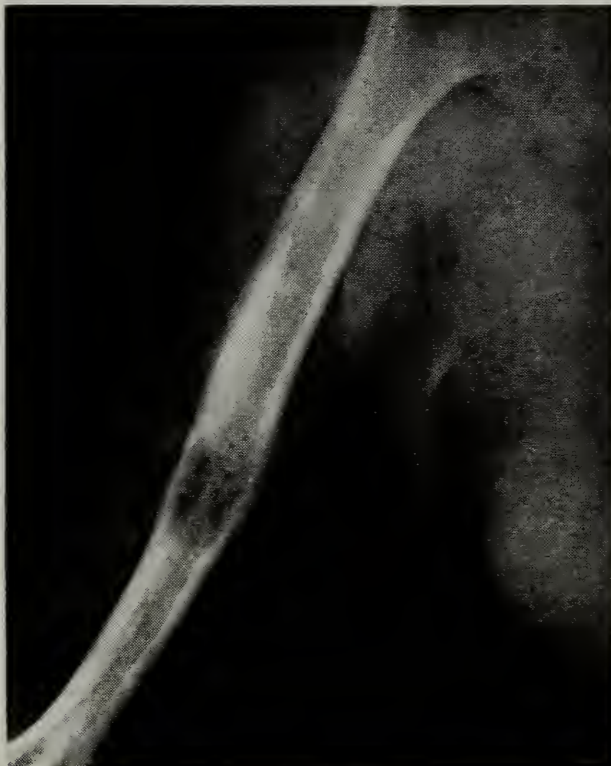


FIG. 4. Left humerus view showing radiolucent oval area in the midshaft infiltrating the cortex and showing periosteal reaction with small perpendicular striations and surrounding soft tissue tumor.

were pain about the tumor formation of the soft tissue at the site of the lesions. After x-ray therapy, these areas resolved (Fig. 5).

On October 20, 1956, she complained of a pain in the left leg but no tumor was found until July, 1957, when the left pelvis showed a large typical lesion. This also responded to deep x-ray therapy.

On February 21, 1957, the patient appeared with another small dusky vascular skin lesion on the right upper lip which responded to well-shielded superficial radiation.

In June, 1957, she noticed that her nose was beginning to bleed easily again and it was slowly becoming more difficult to get air through the nasal passages. During the following month the tumor also recurred at the right angle of the mouth and around the anterior molar region of the right lower jaw and both nares. It was felt that surgical excision was indicated. On July 18, under general anesthesia, a small tumor of the mouth was excised and involved teeth were extracted along with a portion of the underlying mandible. Both nares were curetted to enlarge the orifices and



FIG. 5. Left humerus view three months after radiation. Note the complete reossification.

radium capsules were inserted to control residual nasal tumor. Another skin recurrence on the right upper lip occurred in January 1959 which responded to shielded radiation and local excision.

This covers a study extending over a period of 19 years and to date the patient is well and satisfactorily carries on her duties as a teacher.

Discussion

Until a specific etiology is discovered for each of the group of diseases known as "histiocytosis-X," the problem of differentiating them often becomes a clinical one. Unfortunately, the histopathologic picture offers little to separate them, but when a classic syndrome of Letterer-Siwe disease, Hand-Schüller-Christian disease, or eosinophilic granuloma is manifested, diagnosis becomes easier. It is in such cases as the one presented that classification is difficult if not impossible in the early stages of the disease.

Interesting features such as the presenting symptom of an "epulis" and the marked number of giant cells in the various lesions have been noted in our case. Some cases in the literature of eosinophilic granuloma have presented with gum lesions.⁴ Whether or not such a feature is more characteristic of Hand-Schüller-Christian disease than eosinophilic granuloma or Letterer-Siwe disease bears further study. Despite this, a localized gum swelling presenting the histopathologic picture of "histiocytosis-X" should alert the physician to the possible development of further bony or visceral lesions. The large number of giant cells

observed is an unusual and misleading feature. The significance of such a giant cell reaction is at present unknown.

The physician should always be alert to the probability of a misdiagnosis when he receives a report of giant cell tumor of the jaw. True giant cell tumors in this location are practically unknown. Most are found to be either giant cell reparative granuloma, osteitis fibrosa cystica, epulis, or "histiocytosis-X."

The onset in our patient at age 25 corresponds closely to that of most cases of Hand-Schüller-Christian disease in the young adult. Age may range from 3 to 61 years. In general, eosinophilic granuloma of bone occurs in a like age group. Hand-Schüller-Christian disease like eosinophilic granuloma, shows a slight predilection to occur in males.

While it is generally accepted that Letterer-Siwe disease, Hand-Schüller-Christian disease and eosinophilic granuloma are but interrelated manifestations of a single malady, all of which are ordinarily histologically indistinguishable, it is indeed surprising that the prognosis of each is so different. While Letterer-Siwe disease is invariably malignant and eosinophilic granuloma invariably benign, the mortality in Hand-Schüller-Christian disease may vary from 13 to 40 per cent. Because some of these diseases may run a protracted course or demonstrate apparent transitions from one form to another, it would seem desirable to observe such individuals over a long period of time. For example our unusually long follow-up period of 19 years served to create a complex train of events which led from an obvious solitary lesion to multiple ones.

Radiologically⁵ the lesion may appear as a small or large round or oval area of osseous rarefaction, sometimes with several lacunae. Serial x-ray studies show a rapid progression of the lesion. These areas may appear punched-out, show sclerotic borders, or fade into irregular areas of decreased density. When the mandible is involved alveolar erosion is often severe. Although there is little that is characteristic about the lesion, radiographic findings are suggestive. They have never been reported below the elbow but involvement of the tarsals has been recorded recently.⁶

The final diagnosis should always depend on tissue biopsy. The x-ray appearance of a lesion may closely simulate an osteomyelitis, bone cyst or a giant cell tumor. Multiple lesions may resemble metastatic osteolytic tumors or osteitis fibrosa cystica.

When multiple lesions are discovered, biopsy

or excision of one or more of them will establish the diagnosis and it may be assumed that further lesions are identical. Involvement of the lung and pleura is an occasional serious complication with granulomatous hyperplasia of the peribronchial and interlobular connective tissue and presenting the x-ray picture of interstitial pneumonitis. This may lead to the terminal stages of honeycomb lung, severe fibrosis with emphysema and cor pulmonale. The Nickerson-Kveim test may be helpful in ruling out sarcoidosis.⁶ A lung biopsy may be necessary for a definitive diagnosis.⁷

In this patient, surgical excision or curettage combined with radium or fractional x-ray therapy to a tissue dose of about 800 to 1500 r in one to three weeks appeared to control the lesions adequately. This is slightly higher than that recommended by Childs et al.⁸ Steroid therapy is also well-documented but was not tried in this patient. It seems logical that equivalent doses of suitable radioactive isotopes or alkylating agents should be effective if the lesions are disseminated and serious enough to warrant their use.

Summary

We have presented a case of Hand-Schüller-Christian disease, with bony and visceral involvement, followed for 19 years. Also of special interest was the presenting complaint of an "Epulis" which contained an unusual number of giant cells. Such a pathologic picture was subsequently seen in various other sites. Despite diagnosis in retrospect, empirical therapy controlled the patient for the greater part of 19 years.

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Oliguria Complication

Oliguria of six days' duration occurring in the course of diabetic acidosis is described. The patient recovered, and there was no evidence of renal dysfunction three months later. Renal ischemia and the resulting tubular injury are regarded as the most likely causes of such oliguria.—Clifford F. Gastineau, M.D., Rochester, Minn.: *Minnesota Med.*, 42:1073, August, 1959.

Neurosurgical Significance of The Ophthalmoplegias

Disturbances of eye muscle movement may be the result of surgical lesions in the nervous system at several levels, beginning within the substance of the brain stem itself involving the nuclei of origin of the third, fourth, or sixth cranial nerves or their connections between these nuclei along fasciculus longitudinalis medialis.

The cranial nerves may be also involved in the subarachnoid space between their exit from the brain stem and their entrance into the cavernous sinus. Such lesions are frequently symptomatic of aneurysms of circle of Willis, as such, impose a serious obligation on the ophthalmologist for early recognition and diagnosis. The mortality in the treatment of intracranial aneurysms prior to rupture is now relatively low, whereas the mortality after rupture remains quite high.

Certain conditions which are important in differential diagnosis also involve these nerves within the cavernous sinus proper. A syndrome of what appears to be periarteritis of the carotid siphon was described (in the presentation). ed.

From the neurosurgeon's standpoint, those lesions which involve the oculomotor nerves in the orbit are significant insofar as the intracranial approach must sometimes be employed to remove tumors of the posterior orbit.—Summary of paper presented before the Section on Ophthalmology, Annual Meeting, Ohio State Medical Association, Columbus, April 22, 1959, by William E. Hunt, M.D., Columbus.

The Surgical Approach to Ulcerative Colitis

Pan colectomy (one stage total colectomy and abdominoperineal resection of the rectum) is the preferred procedure for patients requiring operation for ulcerative colitis. The less profoundly ill patients will tolerate the one stage procedure without difficulty and will be spared the risk of additional anesthesia, incision, operative procedure. The more profoundly ill, will derive sufficient benefit from the ablation of the diseased bowel to compensate for the moderate increase in magnitude of the operative procedure and will be spared the dangers of sepsis or hemorrhage attendant upon retention of the diseased rectum in ulcerative colitis. Such patients can tolerate the operation more readily than they can the retention of the diseased bowel.—Mark M. Ravitch, M.D., Baltimore, Md.: *Wisconsin M. J.*, 58:147, March, 1959.

Primary Intrahepatic Cholestasis Due to Hodgkin's Disease With Response to Adrenocorticotropin

BRUCE L. BROWN, M.D.

THE group of cases referred to as primary intrahepatic cholestasis¹ have been an enigma presenting as they do the clinical picture of hepatitis with laboratory tests consistent with obstructive jaundice. The term may include cases due to congenital atresia or inflammatory obliteration of the intrahepatic ducts, cases due to drugs such as arsphenamine, methyltestosterone, or chlorpromazine and to cases of cholangiolitic hepatitis by which term Watson² has designated viral etiology of this syndrome.

Background

A recent report³ suggested that adrenocorticotropin may be of value in differentiating the jaundice of cholangiolitic hepatitis from that of extrahepatic obstruction. It was noted³ that two cases of jaundice with the laboratory profile of obstruction (direct-acting bilirubin, high alkaline phosphatase, normal thymol turbidity and cephalin tests) responded to a course of adrenocorticotropin therapy with a fall in bilirubin level. The suggestion was made that this may afford a new diagnostic aid in the differentiation of cholangiolitic hepatitis from extrahepatic obstruction. Subsequently⁴ this method was employed in 41 patients with various types of jaundice including 18 cases of acute infectious hepatitis, three with "chronic hepatitis," two with cholangiolitic hepatitis, eight with cirrhosis, and 10 with extrahepatic obstruction. No specific pattern of response of the bilirubin levels or the alkaline phosphatase was found in this series.

Liver involvement in Hodgkin's Disease may occur as frequently as in 58 per cent of the cases⁵ but no reports of the types of jaundice could be found in the literature, although it is stated to occur in 10 per cent of the patients with hepatomegaly.⁶

The following case is illustrative of another form of parenchymal liver disease which answers the clinical criteria of primary intrahepatic cholestasis that appeared to respond to adrenocorticotropin at first but later was proved to be due to Hodgkin's Disease involving the liver; these cases are characterized clinically by absence of obstruc-

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tion to extrahepatic bile flow and by laboratory tests reflecting purely regurgitation of obstructive jaundice.³

Case Report

The patient, a 22 year old white man, was first seen October 14, 1956, complaining of jaundice. In 1950 he had noted cervical adenopathy and a biopsy had been done at the St. Vincent's Charity Hospital in Cleveland which had shown malignant lymphoma, Hodgkin's type*; a course of x-ray therapy followed with good response. For the next six years he had been followed elsewhere with no recurrence of adenopathy nor of hilar adenopathy on chest x-ray.

Prior to the onset of the jaundice there had been no loss of appetite or weight and no exposure to hepatitis or to hepato-toxins. Stools were noted to have been light in color and the urine dark.

On examination he appeared well-developed and nourished with obvious jaundice. There was no peripheral adenopathy, the liver margin was palpable, but the spleen was not felt.

Laboratory studies showed a bilirubin of 10 mg./100 cc. direct-acting van den Bergh reaction, alkaline phosphatase of 22 Bodansky units, thymol turbidity of 2 units, cephalin flocculation of 2 plus at 24 and 48 hours, negative Coomb's test, hemoglobin of 13.5 grams and red blood cell count of 4,700,000 per cu. mm.

Because of the possibility of cholangiolitic hepatitis, unrelated to the Hodgkin's Disease, ACTH gel was given 40 mg. intramuscularly daily beginning on October 18. On October 21 the bilirubin had fallen to 2.8 mg./100 cc., the alkaline phosphatase remaining elevated at 19 Bodansky units. ACTH gel was continued 40 mg. every other day until November 17 during which time the bilirubin remained at low, but not normal, levels, being 3.4 mg./100 cc. By November 30 the bilirubin had risen to 14 mg./100 cc. Exploration at this time showed no evidence of extrahepatic obstruction of the biliary system.

The pathological report of the liver biopsy by Dr. Robert J. Williams, was as follows: "Liver shows a cellular infiltrate that diffusely infiltrates all portal spaces causing widening of these areas and in places extends slightly into the liver parenchyma. Beneath the capsule there is a massive cellular infiltrate forming a tumor-like nodule. The cells consist of small lymphocytes and other mesenchymal cells with scanty cytoplasm with fusiform to reniform to a U-shaped nucleus. Here and there are giant mononucleated cells, the nucleus having a large central nucleolus. There are scattered Reed-Sternberg giant cells. In places there is infiltration by leukocytes and

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*These slides were reviewed by Dr. Robert J. Williams.

eosinophils. Throughout the liver parenchyma the bile canaliculi are plugged with bile thrombi. There is an occasional small cellular infiltrate into the lobule. There is no necrosis of liver cells.

"The diagnosis: Hodgkin's Disease of the liver."

Comment

Hodgkin's Disease, then, is another entity that may produce the clinical picture of primary intrahepatic cholestasis. This case further demonstrates the lack of specificity of adrenocorticotropin for cholangiolitic hepatitis and lends further support to the concept of Chalmers³ that adrenocorticotropin may bring about a change in the usual pathways of bilirubin metabolism.

Acknowledgment: The author is indebted to Dr. Robert J. Williams for his contributions.

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Pregnancy and Delivery After Total Pneumonectomy

Ninety-seven women have been reported in the literature as having borne 117 babies after total pneumonectomy. The first of these patients was reported in 1950. . . . In all there were 10 fetal deaths and no maternal deaths. . . . Two more successful cases are reported, one with complicating mitral stenosis, asthma and emphysema. Probably many times as many deliveries have occurred as have been reported.

Pregnancy and delivery are accomplished successfully in these women—usually *via* a low forceps delivery after normal labor. In our second case, operative delivery seemed required because of impending cardiorespiratory decompensation. Very few operative deliveries are reported to be required.

After observing these patients, we feel reinforced in the belief that pregnancy and delivery are such normal events that they usually can be tolerated even by a woman with only one lung. The reproductive careers of such women should be determined by their prospects of living to raise the children they bear.—H. F. R. Plass, M.D., Minneapolis: *Minnesota Med.*, 42:1099, 1959.

Should the Cancer Patient Be Told?

People are much less brittle emotionally than they are given credit for. Physicians are often surprised how well patients can adapt to the knowledge of the existence of cancer. Consequently it is our main thesis that in the vast majority of cases the patient should be told.

The average individual responds to the knowledge with an initial shock reaction which is fortunately relatively short-lived. There is then a gradual integration of the new realities of the situation and their full implications. The patient slowly attains a new picture of himself with altered perspectives, goals, and at times behavior and appearance. This process of successful adjustment can be accelerated and smooth if the following factors are present to a large degree—the history of a good adjustment to previous life stresses; the presence of a successful marriage to a partner with whom the patient can communicate easily; the availability of the truth about cancer humanely delivered, and very important, a warm sympathetic supportive physician who can comfortably enter into a mature and honest patient-doctor relationship when the news is bad as well as good.

With few exceptions patients want to know the truth about themselves and their condition. For the physician and the family to be evasive serves to enforce a climate of isolation in the patient wherein he is unable to discuss his fears and feelings. In addition the patient invariably comes to know he has cancer no matter how well he is "protected" from this knowledge and scarcely knows whom to believe or trust.

If we are ever to negate the notion that a diagnosis of cancer is equivalent to death, which is far from true in a significant number of cases, we must stop acting like it ourselves and discuss cancer freely and honestly but always hopefully with our patients.—Summary of paper presented before the Ohio Cancer Conference, April 21, 1959, at OSMA Annual Meeting in Columbus, by Edwin M. Litin, M.D., Rochester, Minn.

"Biliary Constipation"

A specific form of "biliary constipation" is described. The liver forms subnormal amounts of bile salts. The liver is insufficient in this respect alone. Tests show no other failings. Diagnosis can be made by clinical observation alone. Accuracy of diagnosis is confirmed by response to therapeutic trial of feeding adequate amounts of natural bile salts or desiccated whole bile.—S. S. Lichtman, M.D.: *Am. J. Proctology*, 10:251, August, 1959.

Internal Drainage of Pancreatic Pseudocysts

With Report of a Case

JOHN CARPATHIOS, M. D.

Classification — Pathogenesis

PANCREATIC CYSTS are a relatively rare condition. They are infrequently encountered by the pathologist and less often by the surgeon. Pseudocysts are the most common type of pancreatic cysts in all reported series. In contrast to the true cysts, the pseudocysts, or false cysts, have no epithelial lining, but are, rather, fluid containing sacs with walls of fibrous tissue.

Pancreatic pseudocysts develop following trauma or acute pancreatitis. The majority are the result of severe pancreatitis with necrosis and extravasation of pancreatic enzymes.

The traumatic cysts of the pancreas arise following a crushing blow to the upper abdomen, with compression of the pancreas against the lumbar vertebrae. The trauma causes rupture of the pancreas, followed by outpouring and activation of pancreatic enzymes, with immediate result intense localized inflammatory reaction. The exudate is encapsulated by a fibrous capsule, forming the pseudocyst.¹

Clinical Picture

Epigastric and left hypochondriac pain is the commonest symptom. In many instances, the pain radiates to the back, particularly on the left side. It varies in description from a dull ache to an incapacitating colic.

A smooth round mass can be palpated in most cases, in the epigastric and left hypochondriac region.

The pain and the presence of a mass are the most consistent findings, which along with the history of trauma or pancreatitis—acute or chronic—help in establishing a clinical diagnosis.

X-Ray Findings

Laboratory findings are of little or no value, in contrast to the roentgenographic studies, whose contribution is extremely helpful. In most instances the mass is accurately located by x-ray studies, by the deformity produced in the contour of the stomach, duodenum and jejunum.² (See Fig. 2.)

The problem of differential diagnosis of pancreatic cysts may prove to be quite difficult. Omental and mesenteric cysts and various kinds

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of splenomegalies, may be very confusing. Hydronephrosis, renal cysts and tumors can be ruled out only by careful urological evaluation and intravenous urographic studies.

Surgical Aspects

Every case of pancreatic cyst, when diagnosed, requires operative treatment. If untreated, it may ultimately rupture into the peritoneal cavity, not infrequently with disastrous results, hemorrhage, shock and peritonitis.

Complete excision of the cyst would be the method of choice, if it were possible without serious risk. Unfortunately, in most instances it is not feasible technically to extirpate a large cyst, with a base blending into the pancreatic substance, glued to the surrounding structures and with unusual vascularity of its wall.

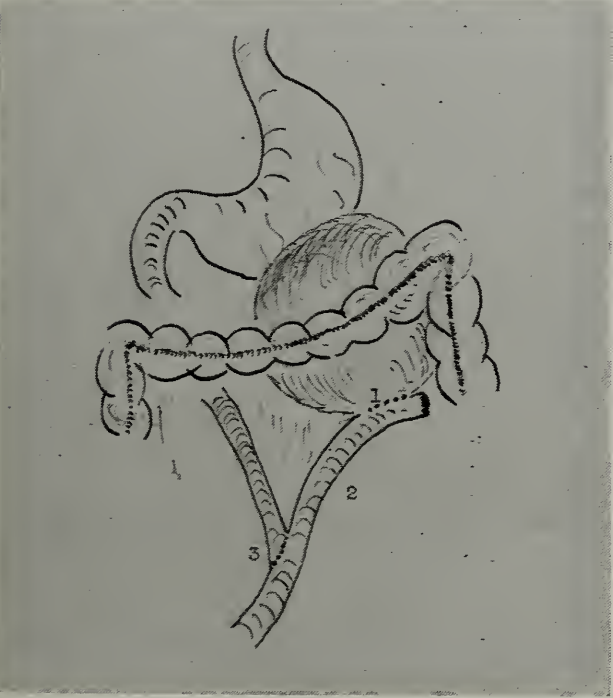
External drainage or marsupialization of the cyst, has been widely used in the past. Sometimes it gives good results, with disappearance of the cyst and permanent closure of the fistula. However, in the majority of cases, a persistent discharge from the fistula, with resultant skin irritation and excoriations, along with depletion of electrolytes and enzymes, becomes a prolonged and troublesome complication.³ Five patients, observed at Mercy Hospital of Canton for the last 15 years, have been treated by this method, which is particularly valuable for pseudocysts whose walls cannot be resected or anastomosed.

In order to prevent all the aforesaid shortcomings of the external drainage, anastomosis of the cyst to the stomach, duodenum and jejunum has been employed (Internal Drainage). Drainage of the cyst into the jejunum seems to be a more physiologic operation and offers a greater adaptability.⁴

Hahn,⁵ in 1927, reported the first side to side cysto-jejunostomy. Several reports followed. In

some instances, however, death occurred from infection, due to regurgitation of intestinal contents into the cystic cavity. This serious objection was successfully overcome by the utilization of the Roux-Y principle in the cysto-jejunostomy.

The operation is easily accomplished by carrying a loop of jejunum through the transverse mesocolon, and anastomosing the jejunal limb to the cyst wall, and then performing a jejuno-jejunostomy, to divert the intestinal stream.⁶ (See Fig. 1.) Antecolic anastomosis can also be per-



1. Cysto-jejunostomy.
2. Roux-Y jejunal limb (12 inch-long).
3. Jejun-jejunostomy.

FIG. 1. Internal drainage of pancreatic cyst (Roux-Y cysto-jejunostomy) as performed in our case.

formed, instead of a retrocolic, if it is dictated by the position of the most dependent portion of the cyst.

This type of procedure not only prevents the loss of pancreatic secretions and overcomes the incidence of septic complications, but at the same time, it reduces the morbidity to only a few days, a factor of great importance, socially and economically for the patient and his environment.

Presentation of Case

The patient, a 57 year old white man, was admitted to Mercy Hospital, Canton, Ohio, on November 3, 1957, complaining of upper abdominal pain, occurring intermittently for the preceding three weeks; no nausea or vomiting or other gastrointestinal disturbances. The patient had been treated last year (1956) for mumps; at that time he was complaining of upper abdominal and mostly left upper quadrant pain (pancreatitis?). On the day of admission he had pain in the epigastrium and left hypochondrium, radiating through to the back of the left side. There was considerable epigastric and left upper quadrant tenderness on palpation and a

large mass, smooth and round, occupying the left hypochondrium, could easily be detected. His temperature was near normal level and there were no abnormal findings from his routine laboratory evaluation (Blood counts, blood chemistry, urinalysis). Radiologic studies showed a large round mass, under the left hypochondrium, displacing the stomach (greater curvature) anteriorly and upwards. (See x-ray picture and drawing.)

Operation

Operation was carried out on November 5, 1957. The peritoneal cavity was entered through a left sub-costal incision. A large mass was encountered in the retroperitoneal space, originating from the body and tail of the pancreas, bulging into the peritoneal cavity, displacing the stomach upwards.

The transverse mesocolon was stretched out over the dependent and protruding portion of the cyst.

The wall of the cyst was exposed through the transverse mesocolon and considerable amount of dark hemorrhagic fluid, clots and pieces of necrotic tissue were aspirated. The cyst was unilocular, firmly attached to the pancreas and bled very easily. It became obvious that its extirpation would be technically impossible. Internal drainage—Cysto-jejunostomy—was decided upon and carried out.

The jejunum was divided at a point several inches below the ligament of Treitz. The distal jejunal stump was closed and inverted and a side to side anastomosis was performed between the distal loop (Roux en Y limb) and the wall of the cyst. The operation was completed by an end to side jejunojejunostomy, which was effected at a distance approximately 12 inches from the cysto-jejunostomy. (See drawing of the procedure.)

The patient had an uneventful convalescence and was



FIG. 2. Large round mass occupying the left upper quadrant. The arrow indicates the upward displacement of the greater curvature of the stomach.

dismissed from the hospital on the eleventh postoperative day.

Follow-Up: On reexamination, three months later, the patient was free from symptoms and the abdominal mass had completely disappeared.

Summary and Conclusions

The classification, pathogenesis, clinical picture and x-ray findings of pancreatic cysts, are discussed.

Special emphasis has been placed on the surgical aspects of the disease. Total excision of the cyst, though the procedure of choice, is in the majority of cases technically impossible without serious danger to the life of the patient.

External drainage—marsupialization—with its prolonged morbidity, skin problem, depletion of electrolytes and enzymes, is of particular value in the treatment of thin wall cysts, which cannot be resected or anastomosed.

Internal drainage of the cyst into the jejunum, by means of a Roux-Y anastomosis, is accepted today throughout the country, as the operation of choice. One case, successfully treated by this method, has been presented.

Acknowledgment: The author wishes to express thanks to Dr. Murray Scott, Jr., for his permission to use the case presented in this article.

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Topical Steroids in Diseases Of the Colon

Topical steroid therapy with hydrocortisone or its analogues has been used in 20 patients having factitial proctitis with prompt symptomatic improvement in 17, though healing was only observed in four instances.

In 27 patients with idiopathic ulcerative colitis, rapid symptomatic improvement and remissions as shown by the proctoscope were observed in 22 (81 per cent) and 20 (77 per cent) patients, respectively. The best results were obtained in early disease involving the rectum and rectosigmoid.

One patient who developed a severe and bloody diarrhea following oral antibiotics responded dramatically to rectal instillations of hydrocortisone.—Marcel Patterson, M.D., and John McGivney, M.D., Galveston, Tex.: *Southern M. J.*, 52:423, April, 1959.

A Not Uncommon Symptom, Dysphagia May Indicate a Multitude of Different Diseases

Difficulty in swallowing or dysphagia is a not uncommon symptom. It may indicate a multitude of different diseases ranging from psychoneurosis to carcinoma. The former usually disappears with adequate assurance and understanding. The latter is a serious disease usually diagnosed too late to cure it. Unfortunately, the severity of early symptoms are not proportionate to the seriousness of the disease. If symptoms are transient, slowly progressive and painless the patient will put off seeking medical advice until his symptoms become quite severe, and the disease too far advanced. Generally, patients put off seeking medical advice hoping the symptoms will disappear and fearing the worst.

Fortunately, most patients presenting themselves in the doctor's office with dysphagia have a benign disease.

The physician who cares for the patient with dysphagia may have a very easy problem. In many, the symptoms suggest the diagnosis. He has a barium study of the esophagus and if necessary, esophagoscopy. The obvious lesions are easily detected by these maneuvers. There is left a small group of patients who have an abnormality that is ill defined and in whom a definitive diagnosis cannot be made.

There is another small group of patients in whom no abnormality can be found but who have persistent symptoms. It is these patients whose problems I wish to discuss. From a diagnostic standpoint, there are two procedures which may throw light on these difficult problems in addition to the standard x-ray and endoscopic examinations. One procedure is cine fluorography. The second is recording of the pressure changes within the esophagus. Both of these methods give additional information which may be of considerable help.

Lastly, we have seen a few patients with dysphagia who have been labelled psychoneurotic but whose problems were quite real. There is nothing that will make a person *seem* to have a serious psychiatric problem more surely than to be unable to swallow normally and to be told by his physicians that there is nothing wrong with his esophagus.—Summary of a paper presented before a joint session of the Sections on General Practice, Internal Medicine and Surgery, 1959 Annual Meeting, OSMA, Columbus, April 22, 1959, by Harvey J. Mendelsohn, M. D., Cleveland.

Orbital Cellulitis

A Case Report on Preventable Blindness

WILLIAM H. HAVENER, M.D.

A BLIND EYE is a serious loss to both patient and community. Awareness of the preventable nature of a significant portion of this blindness should help in reducing the incidence of such tragedies. The representative cases to be presented here are selected to emphasize relatively common causes of blindness which can in many instances be averted by proper, timely care.

Case Report

This 32 year old man developed a red and very painful eye one week ago. Swelling was severe, causing the lids to become tense and bulging. The conjunctiva prolapsed between the lids, and was bathed with purulent discharge. The eyeball itself was displaced forward from the orbit, and its movement was limited in all directions. Visual acuity decreased. Fever, leukocytosis, and general malaise were present. He had been subject to sinus infection in the past.

Upon the strength of a misdiagnosis of scleritis, systemic steroid therapy was begun at the third day of illness and continued for four days. By this time the vitreous and anterior chamber had filled with purulent discharge and the eye was completely blind. The proper diagnosis of orbital cellulitis was belatedly made, and antibiotic therapy instituted. Within a week the inflammatory signs had subsided, but vision was never restored.

Discussion

Spontaneous orbital cellulitis is usually caused by extension from an infected ethmoid sinus. Penetrating trauma with an infected object is the next commonest cause of orbital cellulitis. *Exophthalmos* is the most characteristic finding which permits differentiation from other causes of red eye. (Thyroid exophthalmos does not resemble infection except in rare, exceptionally severe cases.) Exophthalmos is **never** caused by iritis, glaucoma, endophthalmitis, or any other intra-ocular pathology.

Proper therapy includes generous use of *systemic* antibiotics. Topical antibiotics will not penetrate into the orbital tissues, though they may be effective in clearing superficial infection. Cultures are very desirable to identify the causative organism and determine its sensitivity, but should not delay use of antibiotics. Steroids reduce natural resistance to infection and are contraindicated.

Incision and drainage of a swollen orbit is a tempting procedure, but should **not** be attempted. The texture of orbital fat is such that edema, infection, or hemorrhage spread diffusely through the orbit and do not localize. Stab wounds into the swollen tissue will only cause additional injury and open up new avenues for spread of infection. Surgical drainage of an infected sinus should be seriously considered in the presence of marked orbital swelling. Recovery is often dramatic following such sinus

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drainage. Less severe cases subside with antibiotics alone.

Prior to the advent of antibiotics, about half of the cases of orbital cellulitis resulted in cavernous sinus thrombosis and death. Partial or complete loss of vision of the affected eye is common in cases receiving late treatment. The onset of some cases of orbital cellulitis is fulminating, reaching a far advanced stage within a day. Accurate diagnosis and prompt antibiotic therapy is sight-saving and life-saving.

Surgical Treatment Of Strokes

About 40 per cent of patients with neurological syndromes simulating a stroke have atherosclerotic occlusion of the internal carotid artery or vertebral artery rather than small vessel intracerebral disease.

Integrity of cerebral function depends upon a balanced arterial flow through the four major cervical trunks and their intracranial branches. Reduction in flow through the system results from occlusion at any level. Restoration of competent flow through one major trunk may restore the balance to normal.

About 50 per cent of all cases can be benefited by arterial surgery. If the occlusion is partial, 4 out of 5 are improved.

All patients with cerebrovascular strokelike syndromes should have immediate angiography, and, if the syndrome is due to caroticovertebral disease, should have surgery before thrombosis becomes irremovable or brain damage becomes irreversible. If this is done, excellent results may be obtained and a significant number of patients previously with little or no outlook will be salvaged.—Frank R. Denman, M.D., Houston, Texas: *Texas State J. Med.*, 55:563, July 1959.



MATERNAL HEALTH IN OHIO

Case No. 243

This patient was a 35 year old white woman, Para IV, cesarean I, 30 weeks gestation, who died 48 hours after operation. Previous obstetrical history was negative. Last menstrual period May 10. Prenatal course was complicated by severe varicosities of the lower extremities; surgery had been advised and was refused.

The patient was admitted January 1, in extreme shock after being found at home in a pool of blood following rupture of varix of leg (estimated blood loss, 1,000 cc.). In the emergency room the patient received saline, dextran, whole blood and Levophed® for shock. After 5 units of whole blood, there was still no blood pressure. Vaginal bleeding began with increasing tenseness of uterus. Separation of the placenta was suspected; a classical cesarean section was performed. Three more units of blood were given during the operation. A stillborn male infant, 5 pounds 9 ounces, was delivered and partial separation of the placenta found; postoperative blood pressure 100 mm. Hg. There was postoperative oozing from the wound.

Fibrinogen level five hours after admission was 165 mg./100 ml.; 4 grams of fibrinogen were given; therapy also included Levophed, Premarin®, Chloromycetin®, Solu-Cortef® and sludged blood. Medical consultation advised digitalization. Urinary output was 0. Her course progressed downhill. The patient died in 36 hours. The complete blood count 10 hours after admission was red blood cells 3,900,000, platelets 63,840. Sodium and potassium levels were normal. Blood volume studies, also 10 hours after admission, using radioactive RISA, showed a deficiency of 853 ml. in total blood volume, deficiency of 460 ml. in plasma volume and 393 in red cell volume. Autopsy permission was obtained.

Pathologic Diagnoses: (1) Irreversible shock and hemorrhage; (2) terminal right heart dilatation; (3) retroperitoneal hemorrhage, mild; (4) anuria; (5) afibrinogenemia.

Comment

This case was classified by the Committee as a nonpreventable maternal death. It was pointed out that massive hemorrhage from ruptured varicosities in the lower extremities seldom occurs to this extent. Treatment was judged as adequate, if not heroic; facts indicate the circumstances were desperate.

Case No. 161

This patient was a 28 year old white woman, Para VI, 37 weeks gestation, who died five hours postpartum. Previous obstetrical history complicated by twins and preclampsia with first gestation. With her last menstrual period October 10, the patient developed severe symptomatic polyhydramnios one week prior to admission. A flat plate of the abdomen was negative. Cervix

TOPIC THIS MONTH:

Maternal Death* Involving Afibrinogenemia

dilated 2½ fingers and the patient was admitted for elective induction on June 28.

The membranes were ruptured with a 20 gauge needle and the fluid was allowed to escape slowly. There was onset of labor in eight hours with complete dilation four hours later. Contractions became tetanic and placental separation was suspected. With the fetal head at plus 2, forceps delivery was attempted but unsuccessful. An attempt at version brought a sudden gush of blood; uterus still tetanic. Forceps application again was attempted and a dead 5 pound 12 ounce infant delivered, with two lacerations of vagina. Placenta delivered immediately after the infant. The fetus bore an appearance similar to congenital ichthyosis.

Lacerations and episiotomy repaired, during which time blood pressure and pulse became poor; the patient bled even from sutured areas. She was given 6 grams of fibrinogen and 6 pints of blood. Bleeding continued and the blood would not clot. The patient died five hours after delivery; fibrinogen level at this time zero. Permission for autopsy was not obtained.

Cause of Death: Hemorrhage with afibrinogenemia.

Comment

The Committee voted this a nonpreventable maternal death, by a narrow margin. It was noted by the Committee that the report made no mention of uterine exploration from below after the third stage. Irreversible hemorrhage may occur at times, from clotting defect due to lytic substances present; these may not respond to fibrinogen. Further, members wondered if a rupture of the corpus was the cause of continuous postpartum bleeding.

Case No. 234

The patient was a 24 year old woman, Para 0, cesarean II, abortus III, who died seven hours post-delivery (postoperative). She was admitted Novem-

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by official representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

ber 19, one day prior to surgery, for an elective repeat cesarean section at 39 weeks. Previous obstetrical history revealed a cesarean section for the second pregnancy for cephalopelvic disproportion.

Under cyclopropane anesthesia, the day following admission, a laparotrachelotomy was done with minimum blood loss; no blood was given. The patient was returned to the recovery room at 9:15 a. m. in good condition. At 9:30 a. m. bright red bleeding began; Ergotrate,[®] intravenous Pitocin[®] and whole blood were given, also calcium gluconate to no avail. Sterile vaginal examination revealed some uterine atony and the uterus moderately full of clots. Feeling that the bleeding possibly was cervical, two superficial and two deep sutures were placed in the cervix.

The bleeding continued and so the abdomen was reopened; some bright red bleeding in abdominal cavity, no point of origin seen. The uterus was reopened and there was some oozing from the lower uterine segment. Because of the poor condition of the patient an uneventful supracervical hysterectomy was performed. Suddenly, there was a dramatic change in the patient. She began bleeding from the broad ligaments and the blood suddenly would not clot! A clinical diagnosis of afibrinogenemia was made and whole blood and fibrinogen were given. The abdominal incision was closed rapidly. Despite cut down, 3 ampules of fibrinogen and a total of 9 units of whole blood, the condition of the patient became worse and she died seven hours post-surgery. An autopsy was performed.

Pathologic Diagnoses: (1) Term pregnancy, post-operative (cesarean section and hysterectomy); (2) acute afibrinogenemia; (3) amniotic debris in pulmonary capillaries.

Comment

The Committee voted this a nonpreventable maternal death. The occurrence of hypofibrinogenemia following uneventful cesarean section has been reported. In this particular instance amniotic fluid embolism appears to have been the trigger mechanism which initiated this hazardous, futile process. The source or etiology of the amniotic fluid embolus in this case is merely a matter for speculation.

Comment of Consultant

The following comment of a consultant, who is a specialist in Obstetrics and Gynecology, was given at the request of the Committee.

Acute afibrinogenemia is becoming increasingly recognized as a cause of maternal death. It has been attributed to two possible causes: (1) The entrance of thromboplastic substances into the maternal circulation, thereby producing a diffuse precipitation of plasma fibrinogen leaving the blood thereafter incoagulable. (2) The presence of fibrinolytic agents in the blood stream which prevents the formation of an adequate fibrin clot.

Acute afibrinogenemia has been reported in placenta abruptio, amniotic fluid embolism, prolonged intrauterine fetal death, traumatic obstetrical deliveries, ruptured uterus, retained secundines, convulsive eclampsia, missed abortion, postpartum hemorrhage, Pitocin[®] induction with a tumultuous labor, bilateral cortical renal necrosis, pituitary necrosis, hydatid moles, incompatible

blood transfusions, etc. When fibrinogen deficiency is suspected, the "clot observation test" provides a simple and accurate confirmation of the diagnosis.

Once the diagnosis has been made it is imperative that proper management be instituted immediately. To elevate the fibrinogen above the critical level of 100 mg./100 ml. in a patient with little or no circulating fibrinogen, a minimum of 4 grams of fibrinogen must be given at a rapid rate (20 minutes). If the clotting defect is not improved within one hour, an additional 4 grams of fibrinogen should be given. Since the process of defibrination is associated with acute blood loss, then fresh whole blood transfusion becomes mandatory. Additional antishock measures should be kept in mind.

If circulating fibrinolysin is demonstrated (patients blood and clotted normal control = lysis), the patient should receive 100 to 200 mg. of hydrocortisone intravenously. When a heparin-like factor is responsible for the clotting defect, intravenous protamine sulfate is the drug of choice.

Case 243: This represents a patient who went into irreversible shock from acute blood loss, placenta abruptio and a defibrination process. The only constructive criticism is that another 4 grams of fibrinogen was not given in an attempt to further elevate the fibrinogen level above 165 mg./100 ml. A clot observation test should be a *Stat.* routine procedure in all cases of placenta abruptio. Notation of such was not made in this case.

Case 161: Tetanic contractions of the uterus, a traumatic obstetrical delivery and placenta abruptio all contributed to the defibrination syndrome. Whether amniotic fluid embolism occurred remains unknown. An attempt should have been made to demonstrate circulating fibrinolysis. It may have been that this patient would have benefited from hydrocortisone therapy. Poor obstetrical management was demonstrated in attempting to perform an internal podalic version without anesthesia and in the presence of a tetanically contracting uterus. This should have been followed by a postpartum exploration of the uterus to rule out a ruptured uterus.

Case 234: Amniotic fluid embolism seems to explain the etiology of this defibrination process. Regardless of the type of therapy, the outcome is usually fatal.

It becomes apparent from the foregoing and other case presentations that the most important single point in managing defibrination problems is to maintain a *high index of suspicion*. Once the diagnosis has been made, therapy should be instituted without any delay.

A Clinicopathological Conference

Edited Under the Auspices of the Ohio Society of Pathologists

CHARLES BLUMSTEIN, M. D., *President*

Presentation of Case

THIS 55 year old white man was admitted to University Hospital, Columbus, Ohio, because of progressive dysphagia and epigastric pain. Twenty years ago the patient had similar episodes of epigastric distress and was told by his local physician that he had a gastric and duodenal ulcer. He was given a bland diet with antacids and anticholinergic drugs, but these therapeutic efforts brought only little relief. Two and a half years ago the patient noticed dysphagia related to ingestion of meat. X-ray films taken at another hospital showed supposedly gastric and duodenal ulcers. His dysphagia increased in severity despite antacid and anticholinergic drugs.

Three to four months prior to admission even the intake of semiliquid food provoked discomfort and pain. The patient was able to indicate the area beneath his sternum where he thought his food was retained in the lower esophagus. Occasionally his episodes of regurgitation were relieved by drinking a glass of water. A few weeks prior to his admission he began to have intense epigastric pain, mainly three hours postprandial, from which he gained relief by drinking milk or taking soda. His past medical and surgical history was irrelevant. His mother died of angina pectoris at the age of 68.

Physical Examination

The patient was a well developed and well nourished white man in no apparent acute distress. He was alert and cooperative. His blood pressure was 130/80, pulse rate, 78 per minute, respiratory rate 16 per minute, temperature 97.2°F.; weight 195 pounds. The lungs were clear to percussion and auscultation. The heart rhythm was regular and no murmurs were heard. The abdomen was soft and no masses were palpable. Some tenderness was elicited to deep palpation in the epigastrium. Sigmoidoscopic examination including cytological examination was negative up to 15 cm. The prostate showed a grade 2 enlargement.

Laboratory Data

Urinalysis: The specific gravity was between 1.016 and 1.025; many to moderate numbers of white blood cells were noted on three occasions with accompanying rare red blood cells, cellular

Presented by

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- Edited by Dr. von Haam.

and granular casts. *Blood chemistry:* Prothrombin time ranged between 71 and 73 per cent; amylase, 58 Somogyi units; sugar on admission, 115 mg./100 ml.; inorganic phosphorus, 4.6 mg.; alkaline phosphatase, 56 units; calcium, 10.3 mg./100 ml., blood urea nitrogen, 14 mg./100 ml.; CO₂ combining power, 39 vol. per cent, sodium, 135 mEq./L.; potassium, 3.4 mEq./L.; chlorides, 98 mEq./L.; cholesterol, 240 mg./100 ml. Twenty-four hour urinary calcium showed 9.4 mg. One stool was guaiac-negative.

Bacteriology: Several blood cultures were negative. Repeated cultures of catheterized urine showed heavy growths of *Proteus* and *Escherichia coli* and occasionally coagulase-negative *Staphylococci*. One stool culture showed a heavy growth of *Proteus*. The serology was negative for syphilis.

Blood counts: The hematocrit on admission was 58 per cent; it decreased progressively to 42.5 per cent. The hemoglobin on admission was 18.7 per cent and declined to 12.9 per cent. The white blood cell count ranged from 13,050 to 11,500. In the beginning the differential count was normal; however, seven days after admission it showed 91 per cent neutrophils, 7 per cent lymphocytes and 2 per cent eosinophils. Plasma volume determination with I¹³¹-labeled serum albumin showed a whole blood volume of 4870 cc., which was 81 per cent of the expected normal, and a plasma volume of 2270, which was 66 per cent of the expected normal. A gastric analysis revealed a total amount of 2030 cc. of secretion with 240 mEq. of hydrochloric acid present.

X-Ray Examination

Upper gastrointestinal films showed a gastric hiatus hernia associated with peptic esophagitis and a small benign gastric ulcer along the lesser curvature. Also a chronic duodenal ulcer was seen without evidence of obstruction. The chest

film was negative. Repeat study of the lesser curvature of the stomach showed multiple gastric ulcers with suggestion of an old and probably healed duodenal ulcer. Two postoperative chest films were negative.

Hospital Course

The patient was hospitalized for 10 days. A surgical consultation suggested an ulcerogenic tumor of the pancreas. On the fourth hospital day a subtotal gastrectomy, vagotomy and Billroth I anastomosis were performed. On the day of surgery the patient had difficulty in voiding, necessitating several catheterizations. On the second and third days following surgery the patient complained of chest pain and showed diminished breath sounds. Intermittent pressure therapy was of little value. Urinary tract infection was suspected; however, blood and urine cultures were negative. His blood urea nitrogen rose to 40 mg. per 100 ml. On the following day surgical closure of his dehiscence wound was performed and a drain left in place.

During the subsequent hospital days his course was dramatized by bronchial spasms and tachypnea, alternating with episodes of dyspnea and cyanosis. Terminally tachycardia, diaphoresis, and a temperature of 103 to 104°F. appeared, with marked wheezing as a prominent symptom. Therapeutic efforts afforded only temporary relief. On the 10th day of hospitalization the patient had a short episode of ventricular fibrillation and suddenly died.

Clinical Discussion

DR. ZOLLINGER: You will note that this man is 55 and that he had progressive dysphagia and epigastric pain. When patients begin to have difficulty in swallowing at age 55, there is only one diagnosis that would occur to the clinician and that is carcinoma of the esophagus. That is a very disagreeable diagnosis because we know the therapeutic results are probably poorer than in carcinoma of the stomach, and the individual probably has less than one chance in 20 of surviving five years.

Carcinoma

Against this diagnosis is the fact that he had a similar episode 20 years ago. Carcinoma does not come and go over a period of 20 years, although recent medical literature calls attention to the fact that known carcinomas can exist for a long period of time. Another argument against carcinoma is the fact that the patient's weight had not gone down. If you have a carcinoma of the esophagus there is a progressive constriction of the lumen with decreased caloric intake and

without fail the patient must lose weight. This man's weight was described as good, as a matter of fact, as obese.

In the history it did mention the fact that of late he could not eat meat. With patients who do not eat meat I begin to think of the possibility of carcinoma of the stomach. Maybe this is caused by the development of achlorhydria, maybe it has something to do with the lack of digestion of protein, I don't know, but when patients cannot eat meat it generally occurs to me that they may have a carcinoma of the stomach. It might well be that the patient did have a constriction of the esophagus—carcinoma of the esophagus—and that is why he could not take heavy material such as meat.

Achalasia

The second thing I thought we should consider is achalasia, in other words, an obstruction of the esophagus that is intermittent. Against that diagnosis here are the facts that the symptoms have not been persistent, that his nutritional status is too good, and that the patient has reached the age of 55 without having more difficulty. So I would question the diagnosis of achalasia of the esophagus, which I suppose might compare with Hirschsprung's disease of the colon. Should we make a diagnosis of achalasia, we would either recommend the Allison operation, or we would dilate the esophagus with the use of mercury dilators. Since there is no history of the patient ever having swallowed lye or some other strong chemical we also can exclude a benign stricture of the esophagus.

Hypersecretion and Frogs

I would think though that a good bet would be the presence of esophagitis. Dr. Wangenstein at Minnesota has done a lot of work on esophagitis. You know of his experiments on acid peptic digestion in which he places a little frog in a big frog. If he places the big frog in the icebox, nothing happens to the little frog. If he leaves it at room temperature, the next morning there is no little frog. It has been digested. So you can slow down acid peptic digestion at least in the frog by keeping it cold.

Esophagitis means hypersecretion, it means the individual makes too much acid. Dr. Clatworthy and Dr. Sirak performed interposition of a small piece of jejunum between the stomach and the esophagus where the peristalsis would prevent regurgitation and continued digestion of the mucosa by this strong acid. I don't know how frequently it is indicated, because whenever I have been confronted with this problem it has been in

patients where the acid factor was overwhelming, such as we have seen in ulcerogenic tumors of the pancreas.

Hiatus Hernia

When you have a patient with substernal pain that comes and goes, frequent attacks of heart burn, especially if the patient is on the obese side, I think that he has an ordinary hiatus hernia. That would be the most logical diagnosis. A few years ago general surgeons did not pay too much attention to hiatus hernia. That was generally an operation left to the thoracic surgeon, and the hernia had to be of rather tremendous size and was always approached through the thorax. More and more general surgeons have had to appreciate that patients they have operated upon for gallbladder disease or for other types of pathology in the abdomen continued to have the same symptoms: gas, heart burn, indigestion.

In my opinion this is one of the reasons that patients have not been satisfied with the results of biliary tract surgery, because they have had the same digestive symptoms that they had before operation, and that is why general surgeons are beginning to investigate the hiatus. As you know, in this clinic, whenever a patient is subjected to gallbladder surgery we always feel about the esophagus. If the hiatus is 3 or 4 fingers wide (ordinarily it should be rather snug), or if the x-ray man says that the hiatus is somewhat dilated, we then make our incision in the midline and attempt to repair the hiatus hernia at the same time.

Ulcer

Another thing I think we ought to think about when a patient has substernal pain and heart burn and indigestion and epigastric pain is gastric or duodenal ulcer. If you go over the case analysis of this patient you would assume that the individual had a duodenal ulcer because he had his pain two to three hours after the stomach became empty. On the other hand, if he had a gastric ulcer he might have symptoms of cardiospasm, because gastric ulcer on the lesser curvature or on the magenstrasse can certainly give you a reflex cardiospasm or a pylorospasm. So that the patient may have symptoms of esophagospasm or may have symptoms of pylorospasm. As a matter of fact, as we reported at the Annual Session of the American Medical Association in Atlantic City last June, 40 per cent of the patients here with gastric ulcer had associated duodenal ulcer as well.

Ordinarily, according to the literature, no more than 5 to 10 per cent of patients with duodenal ulcer have a gastric ulcer, but gastric ulcers tend to

be associated usually with pyloric obstruction. Perhaps this accounts for dilatation of the stomach. Of course you know from the work of Dragstedt that if you get dilatation of the stomach you get distention of the antrum, and distention of the antrum is adequate stimulation for prolongation of the antral phase of secretion, which produces hypersecretion whether or not the vagus nerves are divided.

We have to discuss gastric ulcer here because the x-ray shows that the patient had a duodenal and a gastric ulcer, and I have just told you that the two go together. Why might the patient have had a gastric ulcer? It is a point that I would like to raise with you.

Role of Drugs

More and more if you dig into the story of patients you find they develop their gastric ulcer when they begin to take treatment for joint pains. You may take aspirin, cortisone, Butazolidin,[®] Bufferin,[®] or any other commercial drugs that are available. Persons tend to accept this as part of their own treatment and they don't count it. We had a man in the ward not too long ago who said he took two patent medicine capsules a week, but when we investigated further we found that he bought two packages each week, but there were 50 capsules in each package and by two he meant he took 100 a week. All that some of us with a tendency to overproduce hydrochloric acid have to do is to take a couple aspirin tablets or aspirin derivatives every 3 to 4 hours and we suffer a good deal of heart burn. So the use of pain-killers for arthritis may induce ulcer, and patients with gastric ulcer may continue to take this even while they are on medical treatment.

Also, I don't want you to forget coffee and tea. The ulcer type patient has a prolonged secretion response to the use of caffeine. So perhaps coffee, tea, chocolate or cola may have just as much or more to do with gastric ulcers than alcohol. Besides I never like to blame alcohol for any such thing as an ulcer.

Now this patient took a lot of soda and as you know that is supposed to be a bad thing to do, especially with pyloric obstruction. As you know, the use of potassium is recommended in cases of pyloric obstruction, hypokalemic alkalosis and vomiting where patients do not respond to the adequate dosage of chloride, sodium, and fluid replacement.

Gastric Analysis

With regard to the laboratory data in this case it is fair to state that the abnormal tests appeared almost all terminally except for the high acid values of his gastric juice. Here this patient had

over 2 liters of fluid with 240 mEq. of hydrochloric acid; which is consistent with the diagnosis of pyloric obstruction commonly found in the presence of gastric and duodenal ulcers as well as in esophagitis. Theoretically from 9 o'clock at night until 7 the next morning you should make about 400 cc. of gastric juice with around 18 to 20 mEq. of acid. This patient produced 5 to 6 times this amount with 12 times the normal amount of hydrochloric acid.

I would like to say just a word about gastric analysis. I doubt if there are 3 per cent of people practicing medicine who know why they do a gastric analysis. When you order a gastric analysis on a patient, try to make up your mind what information you are trying to get. When you stick a tube down into a human stomach, fundamentally you will find out whether the individual has free acid or does not have free acid. If patients do not have free acid and do not have it after histamine stimulation, and have the appropriate symptoms, gastric analysis is invaluable because it makes the diagnosis of pernicious anemia and might help support the diagnosis of carcinoma. If a patient with a history of gastric ulcer has an acidity after histamine, it would certainly be a clear-cut indication for early surgery. But the ordinary gastric analysis where one just sucks out a little juice contributes nothing, and I think there is not a man in this room that could defend an interpretation that he gives to it unless he knows the total volume of gastric juice. That was brought out by Bloomfield of Stanford years ago, and that is why Dragstedt's 12-hour secretion studies are so valuable. You must get the total volume as well as the titration of acid.

Endocrine Tumors

What are some other reasons for hypersecretion? The patient may just have it, the patient may be on steroid therapy or on Butazolidin, he may be taking arthritis pain-killers, or he may have a tumor of the parathyroids. About 25 per cent of tumors of the parathyroids are associated with gastric hypersecretion and produce first kidney stones, then ulcers, and finally bone changes. We all know the relationship between islet cell tumors of the pancreas, hypersecretion and ulceration of the upper gastrointestinal tract. In support of the fact that the pancreas may take predominance over parathyroid tumors is the information gained from Dr. Singleton of Galveston, Texas. There they have had a patient with an intractable ulcer that met this syndrome of islet cell tumor and ulcer diathesis that we have described. When they removed his parathyroid adenoma the ulcer diathesis and the hypersecretion were not af-

fected. Only when the pancreatic tumors were removed was the situation brought under control.

Hazards of Uremia and Jaundice

In referring to the other laboratory studies I would like to say that we would never operate within four days on a patient with an elevated blood urea nitrogen of 40 mg. per 100 ml. and I want to emphasize that pointedly. I have been impressed clinically by the fact that in a patient with a blood urea nitrogen of 40 mg. when they come into the hospital, you should take enough time to hydrate them until the blood urea nitrogen was returned to normal. As Dr. Williams has pointed out in our jaundice patients, when you have patients with a little elevation of the blood urea nitrogen and add a little period of hypotension, they tend to go into uremia. It may be an indicator of renal damage. But this man's blood urea nitrogen was 14 mg. per 100 ml. when he came in or I would have waited.

Dr. Williams has also pointed out in our jaundice patients that you should never let the blood pressure go below 100 systolic. When you do, you tend to get renal shutdown, and that's why we give patients with jaundice 3 units of blood before surgery. In going over this patient's record I found that he never had low blood pressure during surgery, but that night in the recovery room it was recorded that he had a systolic pressure of 80. So it can happen at some other time.

Of course, one of the pitfalls of surgery today is the recovery room. That's where all the dangerous things happen and that is where the young physician ought to spend a lot of time. If a patient with nephritis develops a period of hypotension in the recovery room, that's just the same as if the patient had developed hypotension at the time of surgery. You can predict therefore that there may be a problem of renal output, there may be a problem of an elevated blood urea nitrogen. So watch your patients in the recovery room.

Type of Operation

Now the type of operation that this patient had was a good old classic. He was obese; therefore you can do any type of operation that you want to do. I think that is one contribution that has come from this clinic. The factor that we have attempted to point out is that if you are overweight at the time of operation for duodenal ulcer, it means that you would do well with almost any type of gastric operation. However, if you have lost weight from pyloric obstruction and are on the thin side and have a birdlike appetite, you may not do so well from a nutritional point of

view after a classical resection. I think that is generally accepted now by clinicians all over the country.

So in this patient under discussion today, with a gastric and duodenal ulcer, I would feel that the acid phase certainly would have to be controlled. With 240 mEq. per liter of hydrochloric acid, I would cut the vagus and take out a fair amount of stomach, although Smithwick has shown that after cutting the vagus nerve and taking out the antrum (over half the stomach), there is no need to do any more; you have done the best you can as far as controlling the acid factor is concerned, and that is the principle we have adhered to here. At the time of surgery of course we looked at the pancreas and there were no abnormal signs there. We also looked especially at the duodenum because as Werner pointed out, in adenomatosis of the pancreas you find these nodules of aberrant pancreatic tissue in the walls of the duodenum. We have seen that recently in one patient who had total duodenectomy with total pancreatectomy for tumors in the wall of the duodenum.

Postoperative Complications

How about the postoperative course? Well, everything really happened. We expect the patient with ulcer to do well. The mortality following gastric resection for ulcer should be about the same, or only a little higher than in surgery for gallbladder disease, but with duodenal ulcer it ought to be in the neighborhood of 1 to 2 per cent. Here we began to get into trouble. We had every complication starting with urinary retention.

The point I want you to remember is that when you overlook one factor it is only the beginning of a chain of events, and right here the beginning was urinary retention. That is why we ask the patient to practice using the urinal a little bit. If they do not know how to use the urinal and cannot pass their water they have distress, and by the next morning the patient's bladder capacity is at 1100 cc. If somebody goes in and catheterizes the patient with a technique which leaves something to be desired, cystitis results. Or the patient has a modest hypertrophy of the prostate. That is one of the most common complications that stays with us: the inability to get the patient to start voiding, cystitis, prostatitis, urinary obstruction, and an elevated blood urea nitrogen. This man had all of them.

The same goes for narcotics. When you have a patient under narcotics, quiet in bed, the calves of the legs are flat on the mattress. Dr. Homan used to teach that that had a lot to do with de-

velopment of deep thrombosis in the lower extremities. A man under morphine does not move for five to six hours. Maybe that starts a pulmonary embolus. And when you give a lot of narcotics you get paralytic ileus, distention, and evisceration, and you get dry secretion, suppression of the cough reflex and pulmonary atelectasis. After surgery pain is a protective phenomenon. You need a little pain. That is the chief advantage I feel in retention sutures. They go down under the peritoneum and the peritoneum is very richly supplied with cerebrospinal nerves and is quite sensitive.

So let me tell you again: Train the patient before surgery, teach him to void, train him how to get out of bed, and avoid complications. As far as I know, there is no scholarship, even no national fellowship, available for anybody to treat complications after he has induced them. When you have complications with a patient like this, who eviscerated, had an elevated blood urea nitrogen, and could not get his breath, why was not something done two, three or four days ago to avoid them?

As I recall, this patient had great respiratory difficulties and could not breathe air out, and we were never able to understand it. I suspect that it may have been due to the fact that we had been giving him some drug that we had forgotten about. When a patient gets peculiar rashes, peculiar fevers, peculiar headaches, peculiar reactions that you can't explain, stop all medications and *make sure they are stopped*. That is why we check on his vital capacity, that is why we stop cigarettes, and why we listen at the foot of the bed for his cough. If it is a productive cough we hold off surgery for a while. We do all that and I am sure it was done in this case. Nevertheless he developed these complications and eviscerated. That always adds to our postoperative mortality.

Whether this man had real asthma, I don't know. Ordinarily, I think, when patients do not do well, develop high fever, or complications in the abdomen, we always suspect sepsis. I don't know what was found at autopsy. I would assume that there was some hidden sepsis at some place, and I would be interested to know if the glands of internal secretion could explain his marked hyperacidity.

Clinical Diagnosis

1. Hiatus hernia.
2. Dyspeptic esophagitis.
3. Gastric and duodenal ulcers.
4. Postoperative urinary tract infection.
5. Septicemia (?).

Pathological Diagnosis

1. Arteriosclerotic heart disease.
2. Pulmonary atelectasis.
3. Acute purulent pancreatitis.

Pathological Discussion

DR. VON HAAM: Gentlemen, I feel somewhat akin to this patient. I also had a gastric ulcer once, I also eviscerated once, and I had great difficulty voiding after surgery. I am still alive, thanks to the skill and the postoperative care of Dr. Zollinger.

The clinical diagnosis made by Dr. Zollinger was correct in every detail. We found at autopsy the hiatus hernia, the esophagitis and fibrous stenosis of the esophagus which still permitted a finger to pass through. Unquestionably the patient must have suffered frequent and severe heart burn. In the remaining portion of the stomach a small ulcer was found on the lesser curvature. The ulcer was of the acute type and may have been produced by a gastric tube. The patient's wound was in perfect shape. The anastomosis held tight and no leakage could be detected. Microscopic examination of the endocrine glands showed nothing which could explain the severe hyperacidity of the patient. The kidneys showed a rather acute pyelitis which probably was secondary to his postoperative urinary difficulties.

Heart

The three important organs which we would like to consider in our quest for the cause of death are the patient's heart, his lungs, and his pancreas. The heart was moderately enlarged and the anterior descending branch of the left coronary artery showed marked narrowing of the lumen by an arteriosclerotic plaque covered with a small, well attached thrombus. The thrombus did not obstruct the lumen of the artery completely. The myocardium in addition to some patchy fibrosis showed the changes of severe ischemia without actual infarction as characterized by necrosis and hemorrhage. Many of the smaller coronary branches showed marked arteriosclerosis. The ischemic changes involved mostly the anterior wall of the left ventricle and covered an area measuring approximately 2 by 3 centimeters.

Lungs

The lungs were dark and small and showed a severe degree of atelectasis. No emboli, infarcts or pneumonia were found. The bronchi contained only a relatively small amount of hemorrhagic mucus. There was no histological evidence of bronchial asthma, although the existence of bron-

chial spasm could not be proven or disproven by histological examination.

Pancreas

The pancreas contained numerous small yellowish-white spots found mainly in the head and left portion of the body of the pancreas. Microscopically these areas proved to be foci of recent fat necrosis surrounded by rather pronounced inflammation. Small areas of this type may occur in any abdominal surgical procedure. In this case, however, the lesion was quite extensive and seemed progressive.

The problem we have to decide is which of these three lesions appeared first, and how did they contribute to the patient's death. It is my opinion that the pancreatic lesion, because of the severity of the inflammatory reaction probably preceded by at least a few days the lesions demonstrable in the myocardium and in the lung. We feel that the patient could not have lived as long with his myocardial ischemia or his pulmonary atelectasis as he could with his pancreatitis.

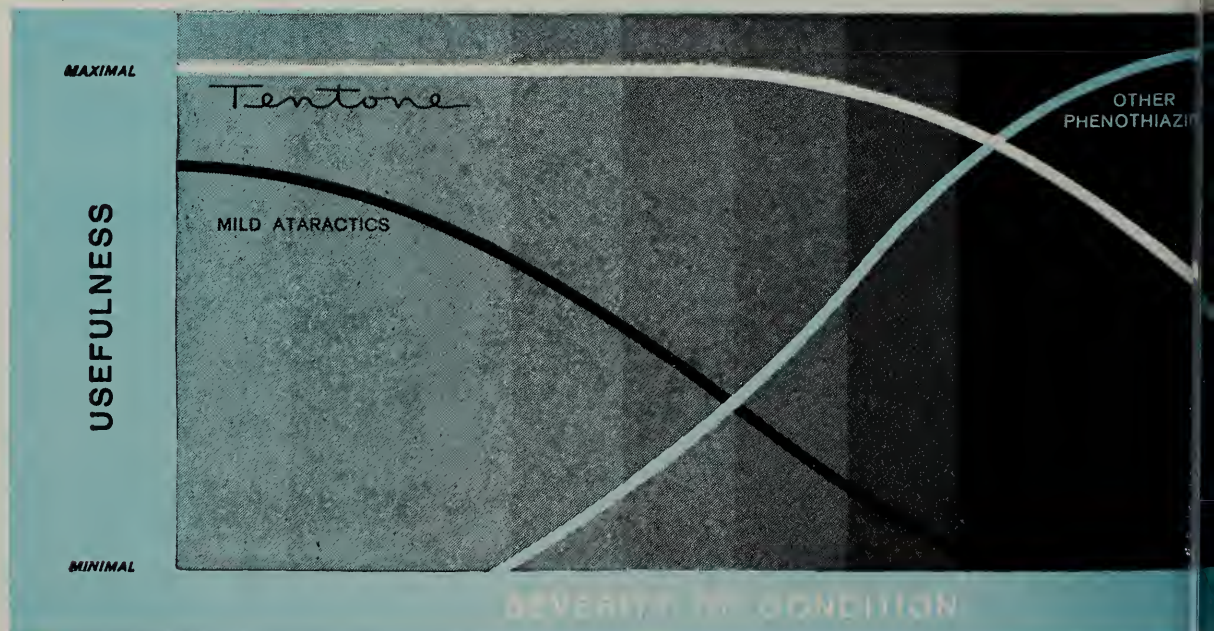
If we feel that the patient died from a coronary occlusion, this of course would mean that his death was not related to his surgery. If we feel that his pulmonary atelectasis was the primary cause of death, we may ascribe this condition to postoperative complications rather than to the operation. If we feel that the pancreatitis was the beginning of his troubles, then the surgical procedure may have been responsible for this fatal outcome. The decision is hard to make.

It is my personal opinion that the postoperative pancreatitis induced severe shock, to which the patient responded by myocardial ischemia in an already damaged heart. This in turn led to acute left ventricular failure with congestion and cardiac asthma. The immediate cause of death was myocardial failure with ventricular fibrillation of the ischemic heart muscle. What do you think about it, Dr. Zollinger?

DR. ZOLLINGER: You came to about the same conclusion as we did clinically. The cardiologist was called in consultation but could not arrive at a clear-cut decision. The existence of postoperative pancreatitis is quite frequent after biliary tract operations and after operations on the stomach. It is usually characterized by a fast pulse rate, backache, abdominal distention and elevated amylase. The latter was not elevated as far as I know. The biggest difficulty from the clinical point of view was the inability of the patient to get his breath. His fever and the high respiratory rate appeared out of proportion. I would agree with you and say that acute cardiac asthma was responsible for the patient's death.

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50 mg. tablets

AMA Clinical Session . . .

Dallas, Texas, To Be Site of Meeting December 1-4; Excellent Program Designed in One of South's Leading Cities; Ohioans Will Participate

THE American Medical Association's 13th clinical meeting December 1-4 in Dallas, Texas, will draw some 3,500 physicians, from all parts of the country.

Planned in cooperation with Dallas physicians, the meeting is designed to help the family physician meet his daily practice problems.

Dr. Everett C. Fox, Dallas, is general chairman of the meeting, while Dr. C. D. Bussey, Dallas, is program chairman.

Ohio's official delegation will participate in proceedings of the House of Delegates, and a number of Ohio physicians will take part in the scientific program.

Among the subjects to be discussed on the scientific program are soft tissue injury; whiplash injuries of the neck; diabetes; heart murmurs in children; new laboratory procedures; new resuscitation techniques; premarital and marital counseling, and the problem child.

Dr. Hubertus Strughold, professor of space medicine at the School of Aviation Medicine, Randolph Air Force Base, Texas, will be principal speaker at the opening scientific session December 1. Dr. Strughold, often called "the father of space medicine," will discuss the role of medicine in the space age.

The winner of the A.M.A.'s Distinguished Service Award at the Atlantic City meeting—Dr. Michael E. DeBakey—will participate in a symposium on the surgical considerations of cerebrovascular insufficiency Tuesday afternoon, December 1. Dr. DeBakey, chairman of the department of surgery at Baylor University College of Medicine, Houston, was given the award for his outstanding contributions to medicine in the field of vascular surgery.

Program and Exhibit

The scientific program, including lectures, symposiums, medical motion pictures, color television, and nearly 100 scientific exhibits, will be held in Dallas Memorial Auditorium. Industrial exhibits will number 251.

The auditorium will also house the "world's largest health fair," sponsored by the Dallas County Medical Society in conjunction with the AMA. The fair will run from November 27 to December 7 and will be open to the public.

The fair will feature 150 educational exhibits,

prepared by the AMA, allied health groups and voluntary health organizations. They will be manned by members of the Dallas society.

The AMA House of Delegates, numbering 208, will meet throughout the week at the Adolphus Hotel, meeting headquarters. The first act of the House will be to name the General Practitioner of the Year. The late Dr. Lonnie Coffin, Farmington, Iowa, was the last recipient of the award, given annually to an outstanding American doctor for his medical and civic contributions to his community.

Convention City

Founded in 1841, metropolitan Dallas now has a population of more than a million persons, with some 680,000 living in the city itself.

Geographically situated at the center of the mid-continent oil fields, Dallas is headquarters for more than 1,000 firms in the oil production and allied industries.

Aircraft production, insurance, finance and banking, electronics, and regional wholesale distribution are the city's other leading industries. It is the home of more insurance companies than any other city in the nation.

Dallas is rapidly becoming a leading convention center, ranking ninth among convention cities in 1958. Its new Memorial Auditorium provides 110,000 square feet of exhibit space in addition to its other facilities for meetings. Dallas has over 200 hotels and motels with some 16,000 rooms.

The Southwestern Medical College of the University of Texas, Baylor Dental School, University of Dallas and Dallas Theological Seminary are also there. It has gained fame as a medical center and now has 29 hospitals. The Dallas County Medical Society has more than 1,100 members.

Mid-West Forum on Allergy Scheduled in Chicago

The Mid-West Forum on Allergy will hold its third annual meeting on October 31 and November 1, at the Sheraton-Blackstone Hotel, Chicago. This meeting of the Forum is sponsored by the Chicago Society of Allergy. For further information, write to Leon Unger, M.D., 185 North Wabash Avenue, Chicago 2, Illinois.

Preview of 1960 Annual Meeting . . .

Schedule of Events for Session in Cleveland Public Auditorium and
Cleveland-Sheraton Hotel, Tuesday, Wednesday, Thursday, May 17-19

FOLLOWING is the schedule of events for the 1960 Annual Meeting of the Ohio State Medical Association. Program details are being arranged by the Committee on Scientific Work and the Section Officers and will appear in later issues of *The Journal*. All events will be on Eastern Daylight Time—Cleveland Time.

TUESDAY, MAY 17

8:30 A.M.

Registration.

9:00 A.M.

Opening of exhibits.

9:30 to 11:00 A.M.

General Session.

Program to be sponsored by the Ohio Division,
American Cancer Society.

11:00 to 11:30 A.M.

Recess for tour of exhibits.

11:30 A.M. to 12:30 P.M.

Continuation of program.

2:00 to 3:00 P.M.

General Session.

Program to be sponsored by the Ohio Division,
American Cancer Society.

General Session.

Program to be sponsored by the Ohio State
Heart Association.

3:00 to 3:30 P.M.

Recess for tour of exhibits.

3:30 to 5:00 P.M.

Continuation of programs.

WEDNESDAY, MAY 18

8:30 A.M.

Registration.

9:00 A.M.

Opening of exhibits.

9:30 to 11:00 A.M.

General Session.

11:00 to 11:30 A.M.

Recess for tour of exhibits.

11:30 A.M. to 12:30 P.M.

General Session.

2:00 to 3:00 P.M.

Section meetings:

Combined session of Section on General Practice, Section on Industrial Medicine and Section on Physical Medicine.

Combined session of Section on Internal Medicine, Section on Nervous and Mental Diseases, and Section on Neurological Surgery.

Combined Session of Section on Neurological Surgery and Section on Otorhinolaryngology.

Section on Pathology.

Section on Pediatrics.

3:00 to 3:30 P.M.

Recess for tour of exhibits.

3:30 to 5:00 P.M.

Continuation of section meetings listed above.

7:30 P.M.

Annual Banquet.

THURSDAY, MAY 19

8:30 A.M.

Registration.

9:00 A.M.

Opening of exhibits.

9:30 to 11:00 A.M.

General Session.

11:00 to 11:30 A.M.

Recess for tour of exhibits.

11:30 A.M. to 12:30 P.M.

General Session.

2:00 to 3:00 P.M.

Section meetings:

Section on Anesthesiology.

Section on Obstetrics and Gynecology.

Section on Ophthalmology.

Section on Radiology.

Combined session of Section on Surgery and Section on Urology.

3:00 to 3:30 P.M.

Recess for tour of exhibits.

3:30 to 5:00 P.M.

Continuation of section meetings listed above.

Adjournment.

AMEF Merits Physician Support . . .

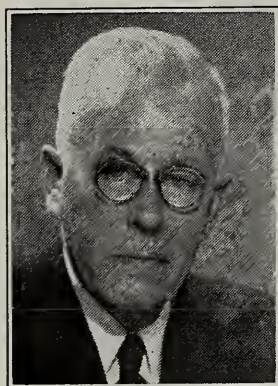
Chairman for Each County in Ohio Is Named as Fall Campaign To Aid Medical Education Gets Underway; Support of Every Doctor Is Asked

OHIO physicians again have an opportunity this Fall to support the Nation's medical schools by contributing to the American Medical Education Foundation.

The Ohio AMEF committee is composed of the 11 District Councilors of the Ohio State Medical Association, with Dr. Merrill D. Prugh, Dayton, a past-president of OSMA as chairman.

The AMEF was founded by the American Medical Association in 1951 to assist medical schools in maintaining high standards of medical education

and to enable them to meet their financial problems without Federal subsidy. The National Fund for Medical Education also was organized to solicit support from business and industry.



Since 1951, the total amount distributed to medical schools by the two organizations has amounted to \$21,859,375. Of this amount, \$7,874,723 was raised by AMEF. Ohio's three medical schools have received the following amounts: Ohio State University, \$332,711; Western Reserve University, \$258,172 and University of Cincinnati, \$269,628.

Gifts to AMEF may be earmarked for a particular school. Such gifts are added to the school's basic grant from unearmarked funds. Donations not specifically earmarked are pooled and distributed among all the schools on the following basis: a uniform gift for each school plus an additional amount determined by the number of students enrolled.

Funds allotted to the medical schools for operating expenses have been used for the improvement of faculty salaries, particularly for younger staff members, and for the purchase of teaching equipment.

Since the first AMEF campaign in 1951, there has been a substantial increase in the amount contributed by Ohio physicians to the national campaign. In 1951, there were 152 gifts amounting to \$5,735. The Ohio contribution reached an all-time high in 1958, with 1,085 gifts amount-

ing to \$41,651.20. Of this amount, \$15,069 was raised by the Woman's Auxiliary to the Ohio State Medical Association, an accomplishment for which the ladies received a national award.

AMEF promotion also has resulted in greater contributions by medical alumni directly to their own schools. During 1958, such gifts by 3,759 Ohio physicians amounted to \$155,871.71. The grand total for Ohio through both sources—AMEF and directly to medical alumni funds—in 1958 amount to \$197,522.91 from 4,844 donors. A comparable figure for the entire country in 1958 was \$4,154,450.22 from 104,976 contributors. Of that amount, 55,246 medical alumni donated \$3,034,405.53 to their own schools, and 49,731 gifts to AMEF totalled \$1,120,044.69. The latter amount includes \$100,000 from the American Medical Association, which also pays all administrative and promotional costs of AMEF.

A direct-mail appeal, followed by local solicitation, is the pattern to be followed again by the Ohio AMEF 1959 campaign committee. The county chairmen are:

First District

ADAMS—Hazel L. Sproull, West Union
BROWN—George P. Tyler, Jr., Ripley
BUTLER—Gilbert P. Wagoner, Middletown
CLERMONT—John M. Coleman, Loveland
CLINTON—Edmond K. Yantes, Wilmington
HAMILTON—Charles A. Sebastian, Cincinnati
HIGHLAND—G. Lyle Morris, Hillsboro
WARREN—D. Paul Ward, Pleasant Plain

Second District

CHAMPAIGN—Arthur B. Ream, Mechanicsburg
CLARK—Lillian M. Posch, Springfield
DARKE—M. W. Johnson, Greenville
GREENE—Harvey B. McClellan, Xenia
MIAMI—William T. Wilkins, Jr., Piqua
MONTGOMERY—Kenneth D. Arn, Dayton
PREBLE—C. J. Brian, Eaton
SHELBY—John H. Kerrigan, Sidney

Third District

ALLEN—Walter E. Yingling, Lima
AUGLAIZE—Elizabeth Y. Kuffner, St. Marys
CRAWFORD—Charles J. Griebing, Galion

(Continued on Next Page)

HANCOCK—Joseph G. Barkey, Findlay
HARDIN—Robert H. Zeis, Kenton
LOGAN—Byron B. Blank, DeGraff
MARION—Ransome R. Williams, Marion
MERCER—Louis J. Finkelmeier, Celina
SENECA—Oswald G. Burkart, Jr., Tiffin
VAN WERT—R. W. Ayres, Van Wert
WYANDOT—F. M. Smith, Sycamore

Fourth District

DEFIANCE—James E. Cameron, Defiance
FULTON—Clarence F. Murbach, Archbold
HENRY—Richard L. Gilson, Napoleon
LUCAS—A. A. Applebaum, Toledo
OTTAWA—Cyrus R. Wood, Port Clinton
PAULDING—V. Bazali, Antwerp
PUTNAM—Charles R. Kidd, Kalida
SANDUSKY—Karl K. Grubaugh, Woodville
WILLIAMS—Russell K. Ameter, Bryan
WOOD—Halford E. Whitacre, Bowling Green

Fifth District

ASHTABULA—Robert J. Zimmerman, Conneaut
CUYAHOGA—Donald B. Cameron, Cleveland
GEAUGA—Alton W. Behm, Chardon
LAKE—Morris G. Carmody, Painesville

Sixth District

COLUMBIANA—A. J. Knapp, East Liverpool
MAHONING—W. H. Evans, Youngstown
PORTAGE—Nathan C. T. Chang, Windham
STARK—B. V. Antes, Canton
SUMMIT—Simon A. Schlueter, Akron
TRUMBULL—Densmore Thomas, Warren

Seventh District

BELMONT—L. D. Covert, Bellaire
CARROLL—Joseph D. Stires, Malvern
COSHOCOTON—Gerald A. Foster, Coshocoton
HARRISON—George E. Henderson, New Athens
JEFFERSON—Robert L. Puncheon, Brilliant
TUSCARAWAS—Samuel H. Winston, Dover

Eighth District

ATHENS—Robert E. Main, Athens
FAIRFIELD—William J. Boswell, Lancaster
GUERNSEY—F. Gordon Lawyer, Cambridge
LICKING—Roland W. Jones, Newark
MORGAN—Henry Bachman, Malta
MUSKINGUM—Walter K. Chess, New Concord
PERRY—A. C. Lawrence, Crooksville
WASHINGTON—W. D. Turner, Marietta

Ninth District

GALLIA—Isom C. Walker, Jr., Gallipolis
HOCKING—Peter Balsys, Logan
JACKSON—Tom Washam, Jackson
LAWRENCE—George N. Spears, Ironton

MEIGS—Edmund Butrimas, Pomeroy
PIKE—Cecil L. Grumbles, Waverly
SCIOTO—Wm. J. Hartlage, Sciotoville

Tenth District

DELAWARE—James G. Parker, Delaware
FAYETTE—Thomas J. Hancock, Washington C.H.
FRANKLIN—David K. Heydinger, Columbus
KNOX—John L. Baube, Mt. Vernon
MADISON—Julio A. Ayulo, Mt. Sterling
MORROW—Andrew Maciurak, Cardington
PICKAWAY—Walter F. Heine, Circleville
ROSS—Lewis W. Coppel, Chillicothe
UNION—James W. Sampsel, Marysville

Eleventh District

ASHLAND—John M. Strait, Ashland
ERIE—Henry W. Lehrer, Sandusky
HOLMES—Neven P. Stauffer, Millersburg
HURON—William B. Holman, Norwalk
LORAIN—Lewis B. Stephan, Oberlin
MEDINA—Donald R. Pinkerton, Lodi
RICHLAND—Melvin M. Christian, Mansfield
WAYNE—Robert E. Schulz, Wooster

More Marriages and More Children per Marriage Add to Baby Boom

The number of married women in the United States reached a total of about 41,500,000 in March 1958, a gain of more than 3,750,000 since 1950 and of about 11,333,000 since 1940, it is reported by statisticians of the Metropolitan Life Insurance Company.

Not only has the number of married women increased, but the proportion of those having babies has increased considerably—from a rate of 125.9 per 1,000 married females aged 15 to 44 in 1940 to 158.8 in 1956.

Larger families are becoming quite common. The birth rate for third and fourth children more than doubled between 1940 and 1956, and that for fifth children almost doubled. And pointing up the trend to younger families, seven of every 10 babies are born to mothers under 30 years of age.

Not only are American wives marrying younger and having larger families, but more of them are working to help support their families. Nearly one third of the wives—about 13 million—were in the labor force in March 1958. Reflecting the tendency of wives to seek work after their children grow up, nearly two out of every five married women in the 45-54 age group have jobs outside the home.

Athletic Injury Conference . . .

Medical Profession Joins with High School Athletic Association in Sponsoring Four Programs for Physicians and School Officials in Ohio

FOUR regional Athletic Injury Conferences will be sponsored during November and December by the Ohio High School Athletic Association and the Ohio State Medical Association.

All will be afternoon meetings, beginning at 1:30 p. m., and ending at 4:30. Registration will be held from 12:30 to 1:30 p. m. They will be held at Worthington, Martins Ferry, Cincinnati and Bowling Green.

The purpose of the conferences, which have been set up jointly by the Committee on School Health of the OSMA, and Commissioner William J. McConnell and the Board of Control of the OHSA, is to emphasize the preventive procedures which should be followed by the schools to the end that every athlete should have the best possible protection for sports participation. Recommended procedures for handling injuries will be discussed, as will referral policies.

Physicians and Educators

Invited to attend the conferences are coaches, athletic directors, faculty managers, school administrators, physical education and health education teachers, physicians, and others interested in prevention and treatment of athletic injuries.

In connection with its action recommending that the OSMA Council authorize this series of conferences, the Committee on School Health of the OSMA recommended that medical societies be encouraged to make certain that a member of the society be in attendance at all football games, either as a school employee or volunteer, and that a member be available for service in emergencies which might develop in other athletic contests. The Council approved both recommendations.

All four Athletic Injury Conference programs will be essentially the same. Each will begin at 1:30 p. m. with a ten-minute review of the background of the conference. The next ten minutes will be devoted to the responsibility of the school administrator in injury prevention, as stated by a school administrator.

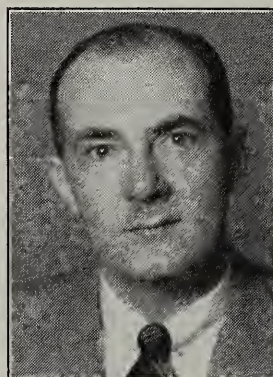
Next will be a ten-minute discussion of the responsibility of the coach, as related by a coach from the area.

Doctors on Program

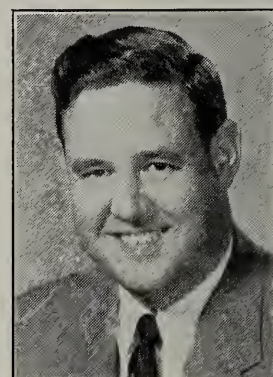
"The Recognition and Referral of Injuries" will then be discussed by Robert J. Murphy, M. D. Dr. Murphy is a practicing physician in Columbus and

is a team physician for the Ohio State University Buckeyes. He will speak for 40 minutes.

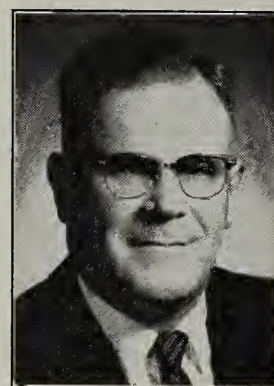
Following a ten-minute coffee break scheduled at 2:50 p. m., Thomas E. Shaffer, M. D., of Co-



T. E. Shaffer, M. D.



Robt. J. Murphy, M. D.



Wm. J. McConnell

lumbus, will discuss "The Medical Qualifications for High School Athletics." Dr. Shaffer is Chairman of the Committee on School Health of the OSMA and a professor in the Department of Pediatrics at the Ohio State University College of Medicine. He will speak for 40 minutes.

The meetings will close with a problems clinic on athletic injuries staffed by the above speakers and physicians from the area.

Dates, sites, and conference directors are as follows. The directors as named are handling physical arrangements, reservations, and other technical details for the meeting in their areas:

Tuesday, November 17:

Worthington Elementary School,
Worthington, Ohio

(Continued on Next Page)

George Robinson, Director, Executive Head,
Plain City, Ohio

Tuesday, November 24:

Martins Ferry High School,
Martins Ferry, Ohio

H. A. Meyer, Director, Superintendent of
Schools, Martins Ferry, Ohio

Tuesday, December 1:

Princeton High School
Cincinnati, Ohio

Angus E. King, Director, Director of Athletics,
Board of Education, Cincinnati, Ohio

Tuesday, December 8:

Bowling Green University Student Union
Building

Sam Cooper, Director, Chairman, Department of Health and Physical Education,
Bowling Green, Ohio

Physicians are urged to attend the sessions in their areas. Reservations may be directed to the area director as listed or to the Ohio State Medical Association, 79 E. State Street, Columbus 15. There is no registration fee.

Wilmington—Dr. H. Richard Bath was re-elected as national president of the Wilmington College Alumni Association.

Buckeye News Notes . . .

Cincinnati—Dr. Robert A. Kehoe, director of the Kettering Laboratory, University of Cincinnati, has received the Air Force Scroll of Appreciation for counsel in occupational medicine. He is consultant to the Air Force surgeon general.

Cleveland—Dr. Joseph B. Stocklin has been appointed by the Cuyahoga County Commissioners as coordinator of health activities involving chronic illnesses and diseases of the aging which will include his present position as coordinator of tuberculosis control.

Cleveland—Dr. Charles L. Leedham was elected president of the American Therapeutic Society at that organization's annual meeting in Atlantic City, June 6. Also he was commended in a resolution adopted by the Cleveland City Council for his work in Civil Defense as chairman of the Disaster-Relief Committee of the Cleveland Academy of Medicine.

Columbus—Dr. J. M. Dunn has retired after 44 years in the practice of surgery.

Dayton—Dr. Thomas P. Sharkey, Dayton, was re-elected treasurer of the American Diabetes Association at its 1959 annual meeting.

Poison Information Centers in Ohio

These centers have agreed to cooperate in a program to extend their services to any physician requesting information from them. When a center is called the physician should have four basic facts in mind: (1) The full name or brand of the product ingested or inhaled; (2) An accurate estimation of the amount of the particular agent ingested; (3) The time of ingestion; (4) The age and weight of the patient.

Location	Facility	Telephone
Akron	Children's Hospital W. Bowery and W. Bechtel	BL 3-5531, Ext. 246
Cincinnati	The Academy of Medicine of Cincinnati 152 E. Fourth St.	PA 1-2345
Columbus	Children's Hospital 561 S. 17th St.	CL 8-9783
Cleveland	Cleveland Academy of Medicine 2121 Adelbert Road	CE 1-4455
Springfield	City Hospital E. High St. and Burnett Rd.	FA 3-5531, Ext. 226
Toledo	Toledo Health Department 635 N. Erie St.	CH 4-1961—(Day) GR 9-2244—(Night)
Mansfield	Mansfield General Hospital 335 Glessner Ave.	LA 2-3411, Ext. 248

Out of the Blue . . .

Some Questions and Answers On the Policies and Operations of Ohio Medical Indemnity, by Physicians' Relations Director of the Company

By R. DEAN DOOLEY, M. D.

Director, Physicians' Relations Department, Ohio Medical Indemnity,
3770 N. High St., Columbus 14, Ohio

HERE are some questions which are asked of Ohio Medical Indemnity—Ohio's Blue Shield Plan—from time to time and what we believe to be the correct answers to them:

Q. Why can you not mail to the doctors of Ohio a complete schedule of indemnities?

A. Compilation of a complete list of indemnities to include all the current multiple contracts would be a project of considerable magnitude. Such a publication would be expensive, quite complex and easily misinterpreted. It would involve costs which we believe would far outweigh any good they would produce. Any physician is welcome to write to our Claims Department and request the indemnity payment on any unlisted condition or conditions, and he will receive a prompt reply.

Q. Have you considered a plan for welfare patients?

A. We do not have under consideration any plan for welfare patients. The feasibility of this approach to the provision of health services to welfare patients has not been established. When convincing arguments are advanced to establish the wisdom of this approach, I am sure we will take our place in line to do our share.

Q. Why does Ohio Medical not pay for circumcisions on infants under 31 days of age?

A. In order to answer this question, we must go back some years when newborns were not indemnified for any professional care for a period of some months. This regulation seemed to work a hardship on cases requiring extensive surgery for the repair of congenital anomalies. So it was determined that in order to do a better job, it would be necessary to remove part of the restriction. We can only write so many benefits into a contract for a given premium rate. Inasmuch as 20 per cent of our claims are obstetrical, any condition occurring as frequently as the need for circumcision while the baby is still in the hospital, would involve a substantial increase in our liabilities and necessitate a premium increase.

Q. Why do you not pay for cut-down on transfusions in infants?

A. Here again, the problem arises—how much can we write into a contract for a given premium rate? Originally, newborns were not indemnified and it has only been in recent years that they have been subject to provisions of indemnification. The only answer I can give to that question is that in the structure of our existing contract, with the present premium rate, there simply is no room to add any new conditions for which we would be obligated to pay benefits.

Q. Are you giving consideration to any type of coverage for office and house calls for medical care?

A. We are not considering inclusion of office calls and house calls in any current OMI contracts. I believe the experience of the companies who have attempted this coverage has been invariably bad. It is most difficult to control utilization. No actuary could come close to estimating the amount of premium required to cover the liabilities such a contract would encompass. It must be assumed that in the course of a year, a family normally expects to meet the expense of a certain number of house and office calls. We expect depreciation in our properties but cannot insure against the expected cost of depreciation, but rather budget an appropriate amount. It seems logical that families should employ the same reasoning in meeting the costs of the normal expectancy of medical expenses.

Q. Can you devise a method of payment to afford some protection for the doctor?

A. Yes, that is being taken care of and in the very near future new claim forms will be issued, upon which there will be printed an assignment clause. When the assignment portion of the form is signed by the patient, the check will be made out to both you and your patient. The patient then will not be able to cash the check until after you have endorsed it. Your endorsement, of course, may be made contingent on your receiving the check.

Medical Civil Defense Conference . . .

Tenth Annual Get-Together of County Medical Societies CD Organizations Will Be Held in Chicago, November 7-8; Excellent Program Is Scheduled

THE Council on National Defense, American Medical Association, is sponsoring the tenth annual conference of the County Medical Societies Civil Defense Organization. The conference will be held at the Morrison Hotel, Chicago, on Saturday and Sunday, November 7-8.

This conference is planned to inform and otherwise assist medical and health personnel for their respective roles in disasters. Conferees have the opportunity (1) to participate in workshop sessions concerning medical preparedness to cope with disasters, (2) to discuss and exchange information dealing with emergency medical services, (3) to be informed on the availability of pamphlets and articles devoted to the medical and health aspects of civil defense, and (4) to hear outstanding speakers report on appropriate civil defense and disaster topics.

On the afternoon of December 1, 1958, fire broke out in our Lady of the Angels' school in Chicago. There were 95 deaths and several hundred school children were casualties. Three months later, a tornado hit St. Louis, Missouri. The toll was several fatalities, 300 casualties, and extensive property damage.

Disasters like these are constantly testing individual and community stamina. They test civil defense preparedness. There is no better way, short of war, to determine the operational capabilities and adequacy of medical civil defense planning.

Two reports at the conference will discuss the hospital and medical disaster programs in operation during the school fire and tornado. Dr. James E. Segraves will report on how St. Anne's Hospital coped with the school children casualties. He is the director of that hospital's disaster plan. Dr. Curtis H. Lohr, a member of the Committee on Civil Defense, Missouri State Medical Association, will report to the conference on "Management of Casualties in St. Louis Tornado."

If Attack Comes

A highlight of the conference will be a talk by Congressman Melvin Price on the environmental and biological effects of nuclear warfare. Recent hearings conducted by a Joint Congressional Atomic Energy Subcommittee assumed that 224 U.S. "targets" were hit by 263 hydrogen bombs with a force of 1,446 megatons, or the equivalent of a billion, 446 million tons of TNT.

The hypothetical attack produced 48,900,000 deaths. In spite of the tremendous number of deaths and staggering number of casualties created by the attack, the one-week hearings ended with the conclusion that the nation could recover from such an attack and that protection measures are feasible and could reduce the casualties considerably. Congressman Price is a member of the Joint AEC Committee.

Biological Warfare

What the physician should know about chemical and biological warfare will be one of the topics discussed at the conference. Major General Marshall Stubbs, Chief Chemical Officer of the Army, as the speaker with this subject, recently said, "In our justifiable concern with the increasing missile and nuclear threat that this nation faces, I am deeply disturbed that we have been and are neglecting an equal risk in the possibility of the use by an enemy of chemical biological warfare."

As a result of testimony by leading military experts on CB warfare possibilities, the House Committee on Science and Astronautics recently urged the trebling of the country's spending on chemical-biological-radiological research and development. The Committee issued a lengthy report recommending an increase to about \$125,000,000 a year for research in this field by the Army Chemical Corps and a program to broaden public understanding of the dangers and uses of CBR agents.

Registration and Reservations

The conference group is self-supporting. As in the past, a registration fee is charged to defray the costs of the two luncheons and other administrative expenses of the conference. The registration fee is \$10.00. Those planning to attend the conference are urged to mail their registration and fees promptly.

The Morrison Hotel, 79 W. Madison Street, Chicago, has set aside a block of rooms for the convenience of conferees. Individuals are urged to write directly to the hotel for reservations, making mention of the conference.

Those desiring additional information about the conference are requested to contact Mr. Frank W. Barton, Secretary, Council on National Defense, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

A Look at Congress . . .

No Final Action Taken This Year on Bills of Special Interest to the Medical Profession; Plenty of Fireworks Next Year Can Be Anticipated

CONGRESS before it adjourned in mid-September took no final action on any legislation of major interest to the medical profession except the annual appropriation for medical research.

However, work was started on three measures of particular concern to physicians—the Forand, Keogh-Simpson and international health research bills. Showdown votes on them are probable next year. If there are not votes next year, they will die and would have to be reintroduced in 1961 if they are to be considered further by Congress.

Forand Bill

The House Ways and Means Committee held hearings on the Forand Bill, but deferred showdown voting on it until next year. The legislation—which is vigorously opposed by the medical profession, other health groups, business organizations, and the Eisenhower Administration—would provide hospital, surgical and nursing home care for federal Social Security beneficiaries. Social Security taxes would be raised to help finance the expensive program.

The Keogh-Simpson bill, after being approved by the House, was left hanging in the Senate Finance Committee. The Senate committee held two sets of hearings. It could vote early next year on the legislation which would grant income tax deferrals to physicians and other self-employed persons as an incentive to invest in private pension plans.

International Research

Chairman Oren Harris (D., Ark.) postponed until next session a vote by the House Commerce Committee on the Senate-approved international medical research bill because of a backlog of more urgent measures requiring committee action this year.

The bill calls for an annual \$50 million authorization to finance a new national institute of health to foster international medical research programs and cooperation. The Administration opposes some of its provisions.

President Eisenhower and Arthur S. Flemming, Secretary of Health, Education and Welfare, made clear that they didn't feel bound to spend the additional \$106 million which Congress voted

for medical research. Congress raised the \$294 million requested by the President to \$400 million.

Wants Brakes Applied

Mr. Eisenhower expressed concern that Congress is going too fast in providing medical research funds which are administered by the National Institutes of Health. He warned of a danger that the quality of research projects might be lowered and that manpower and other resources might be diverted from "equally vital teaching and medical practice."

He directed that every project approved must be "of such great promise that its deferment would be likely to delay progress in medical discovery."

Secretary Flemming said that the President's criteria would be followed conscientiously. But the Secretary gave assurance that the restrictions would not be so rigid as to hamper research by denying funds for worthwhile projects.

Uses Veto Effectively

One of the most important and surprising developments during this session of Congress was the political power shown by Mr. Eisenhower, a lameduck Republican president, in generally calling the shots on legislation although Democrats controlled the House and Senate with substantial majorities.

In his fight against "big spending" measures sponsored by Democrats, the President effectively used his veto power to get the bills more to his liking.

Heart Association To Study Health Fund Problems

The American Heart Association has announced that it would seek the appointment of "an impartial group of physicians, scientists and community leaders" to study the problems arising from the increasing number of fund appeals by health agencies. According to the resolution calling for the study group, the proposed committee would: (1) define the major areas of chronic disease that threaten the nation's health and well-being; (2) set up standards by which potential contributors and volunteers could evaluate the health causes which seek their support.

Postgraduate Programs Scheduled in Various Areas of State Give Ohio Physicians Excellent Choice of Subjects

A list of postgraduate programs sponsored by District organizations and various other groups was published in the September issue of *The Journal*, beginning on page 1247, with details on most of the meetings. Some of these programs were scheduled in September and early October. Here is a list of programs announced to *The Journal* in time to be published in this issue:

October 15-18 — Academy of Psychosomatic Medicine, Hotel Sheraton-Cleveland, Cleveland, (see page 1250, September issue).

October 21 — Columbus Academy Clinic Day, Veterans Memorial Building, Columbus (see page 1251, September issue).

October 21 — Second Councilor District Meeting, Springfield Country Club, Springfield (see page 1251, September issue).

October 21 — Sixth District Postgraduate Day, Packard Music Hall, Warren (see page 1426, this issue).

November 18, 19 — Academy of Medicine of Cleveland, Seminar on Recent Advances in Diagnosis and Therapy of Malignant Disease, 2009 Adelbert Road, Cleveland (see page 1252, September issue).

Eighth District Program in Lancaster October 8, To Feature Cancer

The program of the Eighth Councilor District Meeting in Lancaster Thursday, October 8, has been announced. Introductory remarks will be made by Dr. William D. Monger, Eighth District Councilor.

The scientific session will begin at 2:00 p. m. at the Lancaster Country Club. A cocktail period will follow the scientific session with the Fairfield County Medical Society as host. The Fairfield County Medical Auxiliary will be host to the ladies. Dinner by subscription for doctors and ladies will follow.

The scientific program is as follows:

Cancer of the Lung, Dr. Donald B. Effler, Cleveland Clinic.

Lymphoma, Dr. Charles M. Barrett, professor of therapeutic radiology, University of Cincinnati.

Radiologic Diagnosis of Cancer in Children, Dr. Frederic N. Silverman, associate professor of radiology, University of Cincinnati and Cincinnati Children's Hospital.

The House of Delegates of the AMA has directed AMA representatives on the Joint Commission on Accreditation of Hospitals to suggest to the commission that it inspect, upon request, and consider for accreditation without prejudice those hospitals required by law to admit osteopathic physicians to their staff.

Course in Electrocardiography Scheduled in Columbus

A postgraduate course in Electrocardiography for practicing physicians will be sponsored by the Central Ohio Heart Association, October 12-16 at the Nursing Auditorium, Mount Carmel Hospital, Columbus, O. F. Rosenow, M. D., chairman of the Association's professional education committee, has announced.

The instructor will be Leslie French, M. D., director of medicine and cardiology at the Prince George Hospital, Washington, D. C.

Dr. Rosenow explained that the course is not limited to members of the Association. The fee is \$35.00. With registration, however, limited to 35 physicians, applications are being accepted by the Heart Association in the order in which they are received. For those who can not be accommodated at this session, the course will be repeated November 15-19, he said.

Physicians in Mental Hygiene To Meet

The Association of Physicians of the Ohio Department of Mental Hygiene and Correction will conduct a scientific meeting on Friday, October 9, beginning at 11:00 a. m. The place is the Juvenile Diagnostic Center, 2280 W. Broad Street, Columbus. President of the organization is Dr. Lloyd Covault, of the Orient State Institute; secretary is Dr. Virginia S. Edwards, Mt. Vernon State Hospital.

Physician-Lawyer Code . . .

"Model" Statement of Principles Available To County Medical Societies And Local Bar Associations; Advantages of Joint Project Enumerated

HAVE your County Medical Society and your County Bar Association worked out and adopted a set of principles governing physician-lawyer relationships? If not, you and other physicians should consider asking the officers of your County Medical Society to give this matter prompt consideration.

Officials of both the Ohio State Medical Association and the Ohio State Bar Association believe that the adoption of mutually agreeable codes will produce a better understanding and cooperation between the two professions on many matters and serve as the basis for adjustment of differences which may arise between individual members of each profession.

Model Draft Available

A model draft of a "Statement of Principles Governing Certain Physician-Lawyer Relationships" is available for any County Medical Society which wishes to initiate this project. It was compiled jointly by the Ohio State Medical Association and the Ohio State Bar Association.

The statement of principles, which is appended, has no state-wide force. It is intended only as a "model." It may be adopted locally if agreed to by the local medical society and the local bar association. It may be revised to meet local conditions or views.

It is the recommendation of The OSMA Council that a standing committee of each medical society give this project careful study or that a special committee be named for this purpose. Obviously, the idea should be discussed with each local bar association.

Following is the text of the "model" suggested code:

Text of Proposed Statement of Principles Governing Certain Physician-Lawyer Relationships

Whereas, physicians and lawyers are each members of a profession dedicated to the furnishing of professional skill and service to the public; and

Whereas, a substantial part of the practice of medicine, and of the practice of law, is concerned with medico-legal problems connected with, or arising out of, injuries to, or illness or disability of, members of the public; and

Whereas, certain problems frequently arise in each profession in connection with these medico-

legal problems affecting the relationship between the physician and the lawyer, the physician and his patient, and the lawyer and his client; and

Whereas, the public interest, the interest of the physicians and their patients, and the interests of the lawyers and their clients, will best be served by an understanding on the part of each profession as to the function, scope, rights, duties, and responsibilities of the other profession in connection with such medico-legal problems, and by the cooperation of the members of both professions in the solution of such problems;

Now, Therefore, the following Statement of Principles is hereby adopted by the.....
Medical Society and the.....
Bar Association:

1. Each profession recognizes that practitioners in the other profession have qualified for their particular license and practice by specialized training, and by demonstration of the necessary character and integrity for the service of members of the public:

2. Each profession recognizes that the training, knowledge, skill, advice, and time of the members of the other profession are the means by which such members earn their livelihood, and that the most efficient and effective use of such talents in dealing with any problem involved in, or arising out of, the physician-lawyer relationship requires a due regard and proper consideration for the function, scope, rights, duties, and responsibilities of the other profession with respect to such problem.

A. Reports To Be Furnished By the Physician

1. Authorization of Patient Required.

No lawyer should request of a physician, and no physician should furnish to any person, any information concerning the history, physical condition, diagnosis or prognosis of the physician's patient except upon the signed authorization of the patient (or, in the case of a minor, of the minor's parent or guardian); provided, however, that this principle shall not affect the giving of written medical reports by a physician to the Industrial Commission on behalf of patients whose treatment or examination is to be paid for by the Industrial Commission.

2. Reports to Patient or His Attorney.

The patient, or his attorney as his duly author-

ized agent, shall be entitled, upon written request, to a prompt report from the attending or treating physician concerning the history, findings, treatment rendered, diagnosis and prognosis, and the charge, if any, for such report should be commensurate with the time and effort devoted to its preparation; however, in the absence of unusual circumstances, simple status reports, or simple reports in the nature of a proof of claim or loss, should be furnished without charge.

3. Reports to Others.

Where the physician's report is requested by or on behalf of someone other than the patient or the patient's attorney, the patient's physician should obtain written authorization from his patient before giving the request report or any information relating to his patient; and in such case the physician shall be entitled to charge a reasonable fee for the preparation of such report, the amount of such fee to be agreed upon between the physician and the person requesting the report.

4. Request for Report.

When a medical report is requested of a physician, whether he be an attending physician, consulting physician, or examining physician, the lawyer requesting the report should make clear in his request the specific information desired; should disability evaluation and prognosis be desired, the lawyer should so specify. The physician, upon receipt of such request accompanied by such authorization as may be necessary, should furnish the requested report promptly.

5. Examination of Adverse Party or Employee.

If a medical examination is requested or arranged by a party adverse to the individual to be examined, or by a prospective employer as a pre-employment medical examination, the report of such examination should be made directly to the person arranging for such examination. Unless otherwise authorized or instructed by the person requesting the medical examination, the examining physician should not furnish to the person examined or his attorney, or anyone else, a copy of such report or any information concerning his findings on such examination.

B. Physicians Called as Witnesses in Legal Proceedings: Preparation and Arrangements for the Giving of Testimony: Witness Fees.

1. Conference Before Trial.

It is the duty of each profession to present fairly and adequately the medical questions involved in legal controversies; to that end, the practice of pre-trial discussions, between the physician who is to

testify and the lawyer calling such physician as a witness concerning the medical questions involved, is encouraged and recommended. It is recognized that it is always proper, and in most instances quite desirable from the standpoint of the physician and the lawyer, that a conference should be held between the patient's physician and the patient's lawyer at some mutually convenient time before the physician is to testify. Likewise, the physician who has made an examination of a person at the request of a party adverse to the person examined, and the lawyer planning to call such physician as a witness, should hold a conference at some mutually convenient time before such physician is to testify.

2. Subpoena for Physician; Conference; Conference Fee.

No lawyer should cause a subpoena to be issued for any physician who has examined or treated the lawyer's client without prior conference with such physician concerning the matters regarding which he is to be interrogated, unless the physician and the lawyer agree that such conference is unnecessary, or unless the physician refuses to confer. The fee, if any, to be charged by the physician to the patient for such conference should be a matter of agreement between the physician, the lawyer, and the patient.

No lawyer should cause a subpoena to be issued for any physician employed by the lawyer, or the lawyer's client, to make an examination of a person adverse to the lawyer's client without prior conference with such physician concerning the matters regarding which the physician is to be interrogated, unless the physician and the lawyer agree that such conference is unnecessary, or unless the physician refuses to confer. The fee, if any, to be charged to the lawyer's client for such conference should be a matter of agreement between the physician, the lawyer, and his client.

3. Cooperation With Court.

It is recognized that the proper and efficient dispatch of the business of the courts cannot depend upon the convenience of litigants, the lawyers or the witnesses, including physicians who may be called to testify; both the lawyer and the physician should recognize, accept and discharge their obligation to aid and cooperate with the courts in the presentation of medical testimony.

4. Arrangements for Court Appearance.

In arranging for the attendance of a physician at a trial, or other legal proceeding, the lawyer should always have due regard and consideration for the professional demands upon the physician's time, and, accordingly, the lawyer should whenever possible, give the physician reasonable notice in

advance of his intention to call the physician as a witness, of his intention to issue a subpoena for the physician's attendance, and of the probable date on which the physician will be expected to testify; and the lawyer should also advise the physician to bring with him to court such records as the lawyer or the physician may need for the proper presentation of the physician's testimony. Furthermore, during the course of the trial the lawyer should endeavor to keep the physician advised from time to time as to the approximate hour when he will be called to the witness stand; and upon the physician's appearance at the hearing at the hour agreed upon the lawyer should endeavor to arrange with the court for the prompt calling of the physician to the witness stand.

5. Fee for Court Appearance.

When a physician is called to testify as a witness for his patient, the charge, if any, should be made to the patient. The amount of such charge should be determined by conference between the physician and the patient, or the patient's attorney, well in advance of the physician's appearance in court.

6. Expert Testimony.

A reasonable expert witness fee is a proper and necessary item of expense in litigation involving medical questions; and when a physician is called to testify as an expert witness he should be paid such expert witness fee as may be agreed upon between the physician and the lawyer calling him; and in every instance in which the lawyer makes arrangements for expert testimony it shall be the duty of the lawyer to see that adequate arrangements for the payment of such expert witness fee have been made.

7. Contingent Fees.

Neither the physician called as a witness nor the lawyer so calling him shall invite or enter into any arrangement whereby the making of a charge for the physician's appearance as a witness or for the giving of testimony, or the amount of any such charge, shall be contingent on the outcome of the litigation or on the amount of damages awarded in the case.

C. Settlements

Payment of Physician's Services out of Proceeds of Settlement.

It is recognized that the professional charges of a physician are due when a statement for the physician's services has been rendered to the patient. In any case in which the physician has not been fully paid by his patient, either for his regular professional services or for his time as a witness, or both, and there is no dispute as to the propriety or reasonableness of the physician's charges, the patient's

Five Good Medical-Legal Films Available

Local and district medical societies, medical groups and bar associations can secure any one of five excellent medical-legal films for showing at meetings by writing to the Film Library, AMA, 535 N. Dearborn Street, Chicago 10. They are:

"The Medical Witness," "The Doctor Defendant," "The Man Who Didn't Walk," "No Margin for Error," and the newest of the series of medical-legal films, "A Matter of Fact," about how medical science can help exonerate innocent persons accused of a crime.

The five pictures are co-sponsored by the AMA and the American Bar Association.

lawyer, upon the receipt of the proceeds of settlement of the claim of the patient for an injury, illness or condition for which the physician has treated the patient, or with respect to which injury, illness or condition the physician has testified on behalf of the patient, should request the permission of the patient to pay the physician direct for the physician's charges out of the proceeds in the hands of the lawyer. The lawyer should not charge a fee to the physician for the collection and payment of the physician's charges out of any such proceeds in the hands of the lawyer.

D. Joint Conference Committee

Appointment and Function of Committee

For the purpose of promoting and perpetuating harmony, understanding and improved relations between physicians and lawyers, and for the purpose of improving and revising from time to time this Statement of Principles, a Joint Conference Committee, composed of three physicians and three lawyers, shall be appointed annually by the Presidents of the Medical Society and the Bar Association, respectively. The Joint Conference Committee shall select its own Chairman from among the Committee's members; such Chairmanship shall alternate annually between the members of the Medical Society and the members of the Bar Association.

E. General Provisions

Nothing contained in this Statement of Principles is intended to alter the rules of law with reference to the attendance of witnesses and fees for their attendance, nor the rules of law with reference to privileged communications.

Licensed by State Medical Board . . .

Certificates To Practice Medicine and Surgery Awarded to 358 Graduates Of Medical Schools; Licenses Are Also Issued to Limited Practitioners

RESULTS of the examinations conducted by the State Medical Board of Ohio given June 18-19 were announced by Dr. H. M. Platter, Secretary, following a Board meeting on August 26. Certificates to practice medicine and surgery were awarded to 358 graduates of medical schools.

Certificates to practice Osteopathic medicine and surgery were awarded to 63 graduates of Osteopathic schools. In the limited practice branches, licenses were authorized as follows: Chiropody, 18; mechanotherapy, 6; chiropractic, 14; massage, 15; and cosmetic therapy, 8.

High grade in the examinations for M.D.'s was made by Nicholas H. Kalvin, of Lakewood, a graduate of Ohio State University College of Medicine, with a grade of 90 per cent. Second high in the grades was another Ohio State student, Janet Kennedy Bixel, of Rio Grande, Ohio, with 89.7 per cent. Third place with a grade of 89.4 per cent was John A. Williams, Cincinnati, a graduate of the University of Cincinnati College of Medicine.

Following are the names of those issued certificates to practice medicine and surgery in Ohio. When the home town is different from address at time of examination, the home town is given in parentheses.

Ohio State University — Sam G. Adornato, Youngstown; Richard Verle Albery, Sylvania (Columbus); Charles E. Andre, Toledo (Columbus); Virgil A. Auchard, Columbus; Mary Williamson Bartone, Columbus (Belfast, Ohio); Ronald P. Bell, Toledo (Lima); Jerome P. Bettner, Cincinnati (Montgomery); Janet Kennedy Bixel, Columbus (Rio Grande, Ohio); Wilbur C. Blount, Columbus;

John W. Bohley, Barberton (Cleveland); James D. Bowers, Columbus (Wellston); George W. Bowersock, Columbus (Damascus, Ohio); Andrew V. Boysen, Cuyahoga Falls (Lakewood); Richard A. Brenner, Toledo (Fostoria); Kenneth C. Brinza, Phoenix, Arizona (Lakewood); Joseph J. Browne, Upper Sandusky (Sandusky); B. Patrick Brucoli, Youngstown; William Gerhard Brugge-man, Toledo (Fostoria); John J. Buckley, Youngstown; Bernard L. Bundy, Columbus (North Baltimore);

David L. Call, Circleville; Walter A. Campbell,

Columbus; Larry C. Carey, Columbus; Nathan H. Carpenter, Columbus; Michael J. Casale, McDonald; Louis W. Chosy, Madison, Wisc. (Columbus); Robert F. Chosy, Columbus; David D. Clymer, Columbus; Peter J. Cohn, Cleveland; William T. Coon, Dayton (Port Clinton); Francis E. Cuppage, Cleveland;

Demetrios J. Dallis, Youngstown; David C. Daniels, Dayton (Cincinnati); Robert K. Dean, Toledo (Delphos); Edgar R. Dickson, Columbus (Rocky River); Patricia M. Doyle, Cincinnati; Donald B. Dworken, South Euclid;

William C. Earl, Columbus; Robert C. Ellis, Columbus; John R. Evans, Columbus (Marysville); Michael J. Eymontt, Cleveland; Kenneth J. Faze, Columbus; Raymond S. Federman, Columbus (Akron); Barry M. Fisher, Cleveland Heights; Jerome Fladen, Columbus; Lowell E. Ford, Columbus (Dayton); Lary R. Fout, Columbus (Holgate);

Worthy D. Gemmill, Cleveland; Maynard Goldmeier, Columbus; Robert Lee Goydos, Cleveland; Walter Wesley Hamilton, Columbus; Jerry D. Hammond, Columbus (Middletown); Jerry Medaris Hardacre, Columbus (Wapakoneta); James A. Hathaway, Lindsey; Robert C. Hauver, Cleveland Heights; Sanford A. Hepps, San Francisco, Calif. (Columbus); Ralph A. Herms, Milwaukee, Wisc. (Portsmouth); Douglas S. Hess, Columbus (North Baltimore);

Barry S. Hillman, Columbus; Robert D. Hochstetler, Columbus (Akron); Kenneth R. Holloman, Akron; James J. Houglan, Columbus (Strasburg); Richard C. Hudson, Columbus (Louisville, Ohio); Don R. Huf, Canal Winchester;

John T. Janning, Dayton; Samuel J. Joy, Cleveland; Ralph E. Kah, Columbus (Middletown); Arnold Kahn, University Heights; Nicholas H. Kalvin, Columbus (Lakewood); William R. Kendall, Springfield (Wellston); Richard L. Klecker, Denver, Colorado (Zanesville); Michael A. Klema, Youngstown (Columbus); James T. Krejci, Phoenix, Arizona (Columbus); David Krigbaum, Phoenix, Arizona (Marion);

Harry B. Leslie, Jr., Shaker Heights; Ellis W. List, Jr., Phoenix, Arizona (Bristolville); John LoCricchio, Jr., Youngstown; Robert A. Louviaux, Toledo; Frank A. Luckay, Chagrin Falls; Nicholas

N. Lungociu, Canton; Emily E. Lutz, San Francisco, Calif. (Circleville);

Charles D. Magill, Circleville; John H. Manton, Akron (Centerburg); Raymond E. Matson, Dayton; John A. Mattoni, Toledo; John G. McAnlis, Barberton; John F. McFarren, Denver, Colorado (Dalton);

Herbert I. Medeff, Canton; Nelson Melick, Jr., Roseville; Louis V. Miller, Bowling Green; Turner T. Mills, Jr., Columbus (Cadiz); Ronald D. Moore, New Carlisle; David E. Morgan, Columbus (Granville); Richard L. Morgan, Milwaukee, Wisc. (Akron); Paul S. Morton, Freeport;

Leon Neiman, Akron; Richard S. Olson, Columbus (Fairport Harbor); Chas. Paquelet, Massillon; Charles C. Patterson, Worthington; Robert E. Pumphrey, Jr., Dayton; John G. Randall, Columbus (Portsmouth); James R. Raymond, Rocky River; Jess F. Rhodes, Shaker Heights; Donald W. Rice, Piqua; Max B. Roeder, New Comerstown; Edward C. Rosenow, III, Columbus; Oliver K. Roth, Cincinnati; Sanford H. Roth, Columbus (Martins Ferry);

James L. Schamadan, West Richfield; David Scheetz, San Francisco, Calif. (Rockford); William G. Schetter, Akron; David Selfam, Mansfield; Gary Stuart Shaber, Cleveland Heights; David Sheidler, Cincinnati (Washington C. H.); Deon K. Shortz, Columbus;

John P. Smith, Youngstown; Eugene A. Snider, University Heights; James R. Snyder, Columbus (Akron); Carol A. Spencer, Springfield (Mansfield); Bertram J. Spiwak, Shaker Heights (Cleveland); Ned S. Stevens, Columbus (Cleveland); Crist G. Strovilas, Toronto;

Norman T. Townley, Sunbury; David S. Trump, Denver, Colorado (Cleveland); Thomas W. Tufts, West Palm Beach, Fla. (Hubbard); Victor E. Vaile, III, Galveston, Texas (Columbus); John M. Van Fossen, Jr., Columbus; Joseph A. Vasek, Jr., Phoenix, Arizona (Cleveland); John E. Verhoff, Columbus; Donald G. Vidt, Cleveland (Columbus);

Charles G. Wahoff, Columbus; David W. Watson, Cincinnati (Columbus); William M. Wilson, Columbus (Elyria); Loren J. Yount, Milwaukee, Wisc. (Middletown); James C. Zemer, Fostoria.

University of Cincinnati—Robert W. Albers, Dayton (Ft. Loramie); Elizabeth L. Ankenman, Montgomery (Rentichintala, India); Ralph L. Ankenman, Cincinnati (Montgomery);

Ronald B. Baron, Chicago, Ill. (Cincinnati); H. Hudson Baumes, Cincinnati; Ralph Baumring, Cincinnati; Jesse T. Benson, Orlando, Florida (Toledo); Philip E. Bently, Bay Village; Henry Van Amberg Bielstein, El Paso, Texas (Dayton);

Jerome L. Bramschreiber, Cincinnati; Bernard B. Bruns, Cincinnati;

Thomas R. Carney, Park Hills, Ky.; Doris S. Charles, Cincinnati (Greenville); Willard C. Clark, Jr., Dayton; Robert J. Cole, Hillsdale, Mich.; John D. P. Darrow, Cleveland; A. Robert Davies, Cincinnati; William A. Dawson, Cuyahoga Falls (Bedford); Richard L. Dobbins, Detroit, Mich. (Jackson); Robert G. Draime, Cincinnati (Vincennes, Indiana); Wirt Rexford Duff, South Point;

Glen E. East, Akron; Ronald G. Ebel, Cincinnati; Earl Richard Ebie, Youngstown (Hartville); Thomas M. Evans, Cincinnati; Stanley L. Garber, Dayton; Richard C. Gause, Cincinnati; Irvin Gettleman, Cincinnati; Edward A. Grad, Jr., Cincinnati;

Roger A. Haas, Ft. Thomas, Ky.; Robert S. Harcourt, Indianapolis, Indiana; Howard A. Heringer, Jr., Covington, Ky.; James E. Hoy, Buffalo, N. Y. (Athens); William G. Humphrey, Cincinnati; Harry O. Ingberg, Cincinnati; Donald H. Jansen, South Ft. Mitchell, Ky.;

William H. Kirkham, Jr., Cincinnati (Springfield); Leonard W. Knapp, Santa Monica, Calif. (Willard); Walter R. Lawrence, Cincinnati; Frank F. Ledford, Jr., Dayton; Domingo D. J. Leonida, Cincinnati (Honolulu, Hawaii); Richard C. Lewis, Branford, Conn. (Cincinnati); James E. Massman, Ft. Mitchell, Ky.; Gerald M. Mastion, Cincinnati; George E. Mitchell, Plain City;

George I. Nagao, Cincinnati (Lahaina, Maui, T. H.); Donald B. Nichols, Cincinnati (Lancaster); Salvatore J. Orlando, McKeesport, Pa. (Glassport, Pa.); James G. Osborne, Jr., San Diego, Calif. (Cincinnati); John C. Partin, Cincinnati; Robert Hilleary Poe, Cincinnati (Madeira); David F. Preston, Cincinnati; Merlin S. Puterbaugh, West Milton;

Norman L. Rave, Cincinnati; Clarice D. Reid, Cincinnati; William T. Repasky, Akron; Harvey W. Rice, Providence, R. I. (Astoria, L. I.); James F. Rice, Jr., Cincinnati (Hamilton);

Thomas A. Saladin, St. Ft. Mitchell, Ky.; Robert J. A. Schurdak, Cincinnati (Cleveland); Carl E. Schwenker, Jr., Cincinnati; William T. Scott, Cincinnati; Jerry M. Schuck, Cincinnati; William D. Smith, LaCrosse, Wisc.; Paul D. Stein, Cincinnati; Jean C. Stiens, Cincinnati; David R. Studenberg, Jackson, Miss. (Gregory, S. Dakota);

Roger L. Trinkner, San Francisco (Eastchester, N. Y.); David E. Wade, Cincinnati; Edward W. Walters, Hyattsville, Maryland (Zanesville); John A. Williams, Cincinnati; Fred J. Wilms, Santa Monica, Calif. (Cincinnati); George F. Zinninger, II, Cincinnati.

Western Reserve University—William H. Al-

bers, Cleveland (Canton); Ronald A. Andree, Rochester, N. Y. (Cleveland); Seymour Bakerman, Cleveland; John R. Baringer, Boston, Mass. (Columbus); Frederic Bass, Cleveland; Nina Dawson-Reid Beatty, Akron; Nathaniel Bloomfield, Cleveland Heights; Andrew W. Botschner, Massillon; John R. Briggs, Columbus; James H. Butt, II, Chillicothe;

Julian H. Capps, II, New Haven, Conn. (Cleveland); Dennis J. Carlson, Cleveland; Jackson J. W. Clemmons, Cleveland; Laurence H. Coffin, Jr., Cleveland; Roberta R. Coffin, Cleveland; Ivor J. Davies, Cleveland; Allen E. Doan, Rochester, N. Y. (Miamisburg); Edward F. Doehne, III, (Harrisburg); Richard L. Dunn, Berea;

Richard E. Ellis, Cleveland; Herbert D. Friedlander, East Cleveland; Peter J. Goldblatt, Cleveland Heights; Norton J. Greenberger, Cleveland (Cleveland Heights); Bernard I. Grosser, Cleveland; Jack A. Henderson, Cleveland Hts. (Worthington); Daniel D. Hostetler, Cleveland (Sugar-creek);

Donald W. Junglas, Shaker Hts. (Cleveland); Robert H. Kelly, Cleveland Hts. (Akron); Alan E. Kewish, Cleveland (Chagrin Falls); Arthur F. Kohrman, Cleveland; Paul S. Lavik, Cleveland Hts.; Mary E. Lemmon, San Francisco, Calif. (Cleveland);

Mart Mannik, Boston, Mass. (Ada); Robert W. Merwin, Jr., Cranston, R. I. (E. Palestine); Edward H. Morris, Cuyahoga Falls (Akron); DeMaurice Moses, Jr., Cleveland; Kermit L. Newcomer, Bryan; John J. Nicholas, Cleveland Hts. (Monmouth, Ill.); Robert S. Ort, Cleveland; Judith H. Pfeffer, Minneapolis, Minn. (Cleveland Heights); George B. Rankin, West Hartford, Conn. (Cleveland); Stewart R. Reuter, Springfield; Salvatore G. Rizzo, Cleveland; Harold A. Rosene, Jr., Hanover, N. H. (Cleveland);

Thomas D. Saurwein, Cleveland; Harley E. Schear, Dayton; Robert E. T. Schotz, Lorain; Lawrence J. Schreiber, University Heights (Cleveland); Edward T. Schroeder, Denver, Colorado (Cleveland); Joseph Sciarrotta, Cleveland; Mark B. Shaffer, Jr., Midland, Mich. (Cleveland); Ivan E. Shalit, Cleveland (Detroit, Mich.); Gaius J. Slosser, II, Cleveland; Sanford Summers, Staten Island, N. Y. (Cleveland); George P. Sweda, North Ridgeville;

Joseph P. Thomas, Cleveland (Canton); Mary Jane Tompkins, San Francisco, Calif. (New York, N. Y.); Carl Walter Tyler, Jr., Cleveland; John B. Webster, Oak Park, Mich. (Bellefontaine); Edward C. White, Rochester, N. Y. (Medina); Jean-Pierre Williams, San Francisco, Calif. (Paris, France); Daniel W. Wingard, Cuyahoga Falls

(Stow); James D. Wismar, Berwyn, Ill. (Cleveland); Joseph J. Wityk, Morrisville, Pa.; Don H. Wood, Cleveland (Mansfield); Thomas W. Wykoff, Cleveland Heights; Frank M. Yatsu, Cleveland.

Medical Schools of Other States—(Alphabetically by name of university from which candidate received medical degree):

Sara Siegel Tucker, Cleveland Hts. (White Plains, N. Y.), Columbia Univ.; Eugene René Perrin, Columbus, Cornell Univ.; Earl C. Crispell, Jr., Noxen, Pa., Hahnemann Med. Col.; Anita M. Lamie, Columbus (Bradford, Mass.), Harvard Med. School;

Alfred R. DeCato, Cleveland (Ashtabula); Bernard Goodman, Toledo; Tom D. Halliday, Gallipolis; Charles D. Schloss, Dayton, Jefferson Medical College;

Julius J. Chepey, Jr., Cleveland; Nicholas J. Garritano, Youngstown; Hans E. Geisler, St. Marys; Richard M. Loeffler, Toledo; Valentin F. Mersol, Cleveland; James A. J. Pelagalli, Bedford; Paul J. Raglow, Euclid; Hugh E. Smith, University Hts. (Cleveland) Stritch School of Loyola University.

Ricard J. Alvarez, Akron (Galesville, Wisc.); Robert E. Collins, Toledo (Port Clinton); John T. Goswitz, Columbus (St. Paul, Minn.); Charles J. Pophal, Cleveland—Marquette University.

Meryl H. Haber, Cleveland; Ralph D. Parks, Cincinnati (Zanesville); Kenneth C. Rowley, Columbus (Ravenswood, W. Va.); Ralph G. Spears, Cleveland Heights (LaCrosse, Wisc.)—Northwestern University.

Richard A. Wham, Akron; William P. Winkler, Jr., Akron (Dayton)—University of Illinois.

Leroy B. Goodson, Elyria; Robert W. Oakes, Toledo (Harbor Beach); Donald F. Silver, Toledo (Cleveland); Robert E. Stelle, Toledo—University of Michigan.

Alexander P. Ormond, Jr., Akron, Univ. of Pennsylvania; Clayton E. Culbertson, Akron, Univ. of Pittsburgh; William D. Mize, Rochester (Lake-wood), Univ. of Rochester; John D. Bell, Shaker Heights, Univ. of Utah; Gene V. Ball, Cincinnati (Fairmont, W. Va.), Vanderbilt University.

Canadian Schools: René Cossette, Youngstown (Grand Mere P. Quebec), University of Laval; Frederick W. Trapp, Lima (Grand Marais, Manitoba), University of Manitoba; Thomas J. Egan, Akron, McGill University; Richard E. May, Akron, McGill University; H. Victor Parker, Cleveland, McGill University; Edward B. Claxton (Toronto, Canada), University of Toronto.

Graduates of Foreign Medical Schools (Al-

phabetical by country in which medical school of graduation is located)—

Emil Mason, Cleveland; Naria Krockner Tuskan, Cincinnati—University of Innsbruck, Austria.

Stanley M. Goodman, Redstone Arsenal, Ala. (New York), Catholic University of Louvaine, Belgium.

Maria Mu-Lien Liang, Youngstown, National Sun Yat-Sen University, China.

Roberto A. Cueva, Cleveland; Antonia Perez, Columbus—University of Havana, Cuba.

Jorge A. Leon, Columbus, Central University of Ecuador.

Jerzy W. Bazylczuk, Chicago, Ill., University of Hamburg, Germany.

Myroslav M. Bych, Brooklyn, N. Y., University of Erlangen, Germany.

Wolfgang H. Steinmetz, Cleveland, University of Frankfurt-am-Maine, Germany, West.

Roland J. Adamsons, Staten Island, N. Y.; George A. Graciansky, Barberton—University of Gottingen, Germany.

Gerhard W. F. Schroeder, Orient, University of Hamburg, Germany.

Halbert E. Fillinger, Cleveland (Toledo); Albert Kaltenthaler, Warren—University of Heidelberg, Germany.

Gertrude E. Alexander, Columbus, University of Jena, Germany.

John Chernetzky, Cleveland, University of Konigsberg, Germany.

Vytautas V. Budzeika, Chicago, Ill., University of Munich, Germany.

Demetrios G. Retikas, Akron, Athens National and Capodistria University, Greece.

Marvin Aronoff, Cincinnati; Stanley Baum, Philadelphia, Pa.—University of Utrecht, Holland.

Jackie Ezra Jacob, Ft. Riley, Kansas (Cleveland), University of Calcutta, India.

Manuchehr Moayyed, Columbus, University of Tehran, Iran.

Deirdre Mary O'Connor, Walbridge, Royal College of Ireland.

Joseph F. Orlando, Toledo (New York City), University of Bologna, Italy.

Cesare A. LaRuffa, Terrace Park, University of Messina, Italy.

Anthony H. Bartolo, Toledo (Valletta, Malta), University of Milan, Italy.

Frank A. Chianese, Pittsburg, Pa.; Vincent D. Lepore, Youngstown—University of Rome, Italy.

Masahiro Chiga, Salt Lake City, Utah, University of Tokyo, Japan.

Carlos G. Manzano, Wheeling, W. Va.

Jack Sobel, Petersburg, Va., National Autonoma University of Mexico.

Helen Dean, Iowa City, Iowa (Manila, Philippines), Manila Central University, Philippines.

Carmen T. Theodoro Reyes, Strongsville; Francisco A. Reyes, Jr., Strongsville—University of the Philippines.

Manuel B. Rodriguez, Cleveland Heights, University of Santo Tomas, Philippines.

Edmund L. Kaminski, Cleveland, University of Poznan, Poland.

Ahmet Samedov, Hammonton, N. J., Turkmenian State Medical Institute, Russia.

Samuel Kaplan, Cincinnati, University of Witwatersrand, South Africa.

Morton Kalker, Youngstown, University of Basel, Switzerland.

Milan D. Shijacki, Joliet, Ill., University of Belgrad, Yugoslavia.

* * *

Licensed Through Endorsement by State Medical Board

The State Medical Board of Ohio has issued licenses to practice medicine and surgery in the State to the following physicians through endorsement of their licenses to practice in other states, or certification by the National Board of Medical Examiners (included are intended residence and medical school of graduation):

June 18—Joseph M. Cavallaro, Gallipolis, Univ. of Maryland; John E. Eckerle, Dayton, Univ. of Louisville; John Freedom, Birmingham Medical School, Birmingham, England; Stanley J. Jallo, Jr., Cleveland, Hahnemann Medical College; Thomas J. Joynes, Cleveland, Howard Univ.; James A. Rourke, Columbus, Tufts Univ.; Russell A. Scott, Cleveland, Howard Univ.; Edward J. Winter, Cleveland, Marquette University.

August 26—Heino Alari, Toledo, Univ. of Tübingen, Germany; Muvaffak A. Atamer, Toledo, Ankara University, Turkey; William M. Blackwell, Columbus, Tufts University; Yves H. Boennec, Lakewood, Univ. of Paris, France; Albert J. Brinz, Univ. of Santo Domingo, Dominican Republic;

William J. Barrison, Jr., Salem, The George Washington Univ.; George B. Brothers, Cleveland, Meharry Medical College; Clement R. Brown, Jr., Dayton, Georgetown Univ.; Edward J. Burger, Jr., Lorain, McGill University; George W. Butz, Jr., Toledo, Northwestern Univ.; Ronald W. Byledbal, Columbus, Univ. of Buffalo;

Lucian F. Capobianco, Parma Heights, Loyola University; John A. Carlston, Yale University; Phill I. Cohen, Columbus, Baylor University; Rodney L. Crislip, Cleveland, Western Reserve Univer-

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*Pratt, R. T. C., and McKenzie, W.: Anxiety States Following Vestibular Disorders, *Lancet* 2:347 (Aug. 16) 1958.

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sity; John R. Cummings, Cincinnati, Univ. of Cincinnati; Charles W. Denko, Columbus, Johns Hopkins Univ.; Prentiss M. Dettman, Columbus, Harvard Medical School; Robert V. Diserens, Columbus, Yale University; Kyrill Dosseff, Cleveland, Univ. of Sofia, Bulgaria; Virginia A. Dulany, Cincinnati, Columbia University;

Corinne S. Eddy, Cuyahoga Falls, Univ. of Illinois; Trygve O. Gabrielsen, Univ. of Washington; Cary B. Gardner, Cleveland, Univ. of Geneva, Switzerland; James R. Geyer, Cleveland, Northwestern Univ.; David A. Goldthwait, Cleveland, Columbia Univ.; Ramon M. Greenberg, Cincinnati, Harvard Medical School;

Allen T. Hardy, Columbus, Temple Univ.; Bruce D. Harrold, Massillon, Jefferson Medical College; Richard C. Hirschhorn, Cleveland, Harvard Medical School; Donald H. Hofreuter, Cincinnati, Columbia Univ.; Marvin L. Hoovis, Univ. of Lausanne, Switzerland;

George W. Irmischer, Cleveland, Univ. of Michigan; C. Richard Johnson, Dayton, College of Medical Evangelists; Dean R. Johnson, Columbus, College of Medical Evangelists; Anton Jurkans, Univ. of Latvia;

Vitalijs Kaspari, Univ. of Heidelberg, Germany; Emanuel Kauder, Cincinnati, New York Univ.; John F. Kelley, Columbus, McGill Univ.; Melvin J. King, Gallipolis, Cornell Univ.; Harvey E. Knoernschild, Columbus, Univ. of California;

Frederic W. Lafferty, Cleveland, Harvard Medical School; Bernard R. Landau, Cleveland, Harvard Medical School; John Lanzkron, Univ. of Hamburg, Germany; Alexander N. Levay, Cleveland, Univ. of Rochester;

Stephen A. Mahoney, III, Shaker Heights, Tufts Univ.; Alvin M. Mauer, Cincinnati, State Univ. of Iowa; Hugh B. McCullough, Columbus, Northwestern Univ.; Robert E. Milani, Akron, Northwestern Univ.; Clarkson T. Palmer, Bellaire, Univ. of Pennsylvania; Stephen I. Pellathy, Univ. of Budapest, Hungary; Marvin L. Perry, Cleveland, St. Louis Univ.; Norman L. Roulet, Cleveland, Univ. of Pennsylvania; Michael J. Russo, Georgetown Univ.;

Adolph S. Schlesinger, Univ. of Leiden, Netherlands; Robert Schwartz, Cleveland Heights, Yale Univ.; Stanford S. Setnor, Syracuse Univ.; Peter W. Shenon, Columbus, McGill Univ.; Charles R. Shepardson, Cleveland, Univ. of Rochester; William P. Sinclair, Akron, Medical College of Virginia;

Oley D. Snylyk, Dayton, Univ. of Erlangen, Germany; Alfred I. Spieler, Akron, Boston Univ.; David L. Steinem, Toledo, McGill Univ.; Cornelius N. Stover, Columbus, Hahnemann Medical

College; Dennis J. Sullivan, Cambridge, Marquette Univ.;

John T. Taylor, Dayton, Univ. of Michigan; Marguerite E. T. Thompson, Cincinnati, Univ. of Louisville; George A. Turman, Univ. of Belgrade, Yugoslavia; Michael Vassallo, Cleveland, Tufts Univ.; Edward M. Wallerstein, Cleveland, Univ. of Lausanne, Switzerland; Joel S. Webster, Dayton, Univ. of Maryland; Harry E. Wilson, Jr., Cleveland, George Washington Univ.; Edward A. Zemer, Parma, Northwestern University.

Openings for Local Health Commissioners Listed

The Ohio Department of Health has been requested to assist several local health districts in filling the positions of health commissioners.

Mr. Edward Graber, assistant chief, Bureau of Local Service, ODH, said that efforts are being made to fill several vacancies, and invited interested physicians to contact him, particularly those with public health experience.

Mr. Graber said the requirements include an Ohio license to practice medicine. He may be contacted at the State Office Building, Columbus.

Impairments For 12-Month Period Total 24,000,000

Not counting military personnel or civilians in mental or other long-term institutions, the American people had, all told, about 24 million impairments during the 12 months July 1957 through June 1958. The impairments included such chronic or permanent defects as paralysis, deformity, and total or partial loss of hearing and vision. This was the finding in the latest in a series of published statistical reports (Publication No. 584-B9) issued by the U. S. National Health Survey of the Public Health Service. The rate of impairments during the 12-month period was 141.4 per 1,000 persons in the civilian, non-institutional population.

Blindness—defined as the inability to read ordinary newspaper even with the help of glasses—was reported for an estimated 960,000 people, a rate of 5.7 per 1,000 persons. In addition, 2,064,000 people were reported to have visual impairments less severe than blindness, the rate being 12.3 per 1,000.

About 109,000 persons were reported as totally deaf, a rate of 0.6 per 1,000 persons; and other hearing impairments affected 5,714,000 individuals, a rate of 33.9 per 1,000.

Other conditions reported frequently were paralysis and other defects of the limbs, back, and trunk; and speech defects.

practical program for physicians who want first hand review of the latest approaches patient care.

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the 1959 clinical meeting

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Dallas, population 1,050,000, is rapidly becoming one of the great convention centers of the nation. It combines old fashioned Texas hospitality with some of the most modern convention facilities to be found anywhere. It has excellent skyscraper hotels, and numerous night clubs and restaurants presenting top-flight entertainment.

Cultural facilities include the famous Margo Jones theatre, the Dallas Civic Opera and the Dallas Symphony Orchestra.

PROGRAM HIGHLIGHTS

The Role of Medicine in the Space Age—Hubertus Strughold, Professor and Advisor for Research, School of Aviation Medicine, Randolph AFB

Indications for Hysterectomy—Willis H. Jondahl, Harlingen, Texas—Lecture

Rheumatoid Arthritis—W. Paul Holbrook, Tuscon, Ariz. Panel Moderator

Colloidal Isotopes and Leukemia—Joseph M. Hill, Dallas—Lecture

Treatment of Diabetes—Randall G. Sprague, Rochester, Minn.—Panel Moderator

Infectious Diseases in Children—Harris D. Riley, Jr., Oklahoma City—Panel Moderator

Tranquilizers in Medical Practice—Stewart Wolf, Oklahoma City—Lecture

Surgical Approaches to Parkinson's Disease—William W. McKinney, Fort Worth—Lecture

Congestive Heart Failure—James V. Warren, Galveston—Panel Moderator

Peptic Ulcer in Rheumatoid Arthritis—Lloyd G. Bartholomew, Rochester, Minn.—Lecture

Immunization and its Future—Blair E. Batson, Jackson, Miss.—Lecture

Children's Eyes—Tullos O. Coston, Oklahoma City—Lecture

Obstetrical Emergencies—Willis E. Brown, Little Rock, Ark.—Panel Moderator

Hernia Repair—Francis C. Usher, Houston—Lecture

Premarital and Marital Counseling—Oren R. Depp, New Orleans—Panel Moderator

Anticoagulants and Choice of Drugs—James W. Culbertson, Memphis, Tenn.—Lecture

SYMPOSIA

Anemia • The Problem Child • Iatrogenic Disease • Soft Tissue Injury • Biliary Tract Surgery • Intestinal Obstruction • Carcinoma of the Breast • Cerebrovascular Insufficiency

Workmen's Compensation . . .

More Than \$9 Million Was Expended for Medical Services to Injured Ohio Workers During Year; Report Shows Some Additional Expenses

THE Ohio Bureau of Workmen's Compensation during the calendar year 1958 paid out \$9,022,434.31 for medical services to injured Ohio workers, according to information provided by the Actuarial Section of the Bureau. That amount excluded a small sum for dental services.

Other 1958 expenditures, exclusive of compensation payments, included the following: \$11,195,584.89 for hospital care and nursing. \$199,324.17 for funeral expenses, and \$39,329.70 for miscellaneous costs. With disbursements for medical expenses added, the total is \$20,456,673.07.

These amounts include payments covering treatment of injured private and public employees as well as similar costs for occupational disease claims.

Comparative figures for 1957 were as follows: \$7,827,104.24 for medical services to injured workers; \$9,749,720.37 for hospital care and

nursing; \$214,444.22 for funeral expenses, and \$61,179.26 for miscellaneous expenses; a total of \$17,842,448.09.

The number of claims filed during 1958 was 283,807 or 14 per cent less than in 1957.

Medical only claims filed involving payments for physicians' services, but with no compensation for the claimant for loss of time, numbered 220,700 for 1958, or 78 per cent of all claims filed. The average amount paid out for medical-only claims decreased from \$22.72 in 1957 to \$20.68 in 1958.

Table 1 is a financial statement of the Ohio Insurance Fund.

Table 2 gives the 1958 awards that have been made to active claims according to the year of injury and having injury dates which in some cases reach back to the beginning of the fund in 1912.

TABLE 1
OHIO STATE INSURANCE FUND
(Workmen's Compensation)

STATEMENT OF FINANCIAL CONDITION					
as of December 31, 1958					
ASSETS					
	Private	Public	P.W.R.E.	Safety & Hygiene	Total
Cash	\$ 3,640,529.13	\$ 210,778.24	\$ 12,039.99	\$ 45,014.34	\$ 3,908,361.70
Bonds	294,974,766.00	17,073,927.00	987,434.00	3,652,048.00	316,688,175.00
Premiums in Course of Collection	37,001,445.62	6,393,569.98	42,682.53	-----	43,437,698.13
Accrued Interest	1,825,593.08	105,670.19	6,111.21	22,602.45	1,959,976.93
Administrative Cost Assessment	48,432.77	26,508.24	-----	-----	74,941.01
Total Assets	\$337,490,766.60	\$23,810,453.65	\$1,048,267.73	\$3,719,664.79	\$366,069,152.77
LIABILITIES					
Reserve for Compensation and Medical	\$277,443,833.42	\$23,773,170.75	\$ 172,693.03	-----	\$301,389,697.20
Advance Premium Deposits	42,158,469.90	-----	-----	-----	42,158,469.90
Fund	-----	-----	-----	3,719,664.79	3,719,664.79
Reserve for Contingencies and Surplus	17,888,463.28	37,282.90	875,574.70	-----	18,801,320.88
Total Liabilities	\$337,490,766.60	\$23,810,453.65	\$1,048,267.73	\$3,719,664.79	\$366,069,152.77

TABLE 2—PRIVATE FUND
Medical, Hospital, etc., Awards Distributed to Year of Injury Occurrence
(Accident and Occupational Disease Combined)

Year of Accident or Disease	Awarded	1958 Per Cent	1957 Per Cent
1958	\$ 7,091,249	38	37
1957	5,489,169	30	28
1956	1,735,703	9	8
1955	824,910	4	4
1954	524,104	3	3
1953	496,249	3	2
1952	653,803	4	4
1951	259,160	1	2
1950	274,809	1	2
1949	227,717	1	1
1912-1948	982,074	6	9
Total	\$18,558,947	100	100

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pyrilamine maleate 12.5 mg.)

Dormethan
(brand of dextromethorphan HBr) 30 mg.
Terpin hydrate 180 mg.
APAP (N-acetyl-p-aminophenol) 325 mg.

References: 1. Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958. 4. Bonica, J. J.: in Drugs of Choice, Mosby, St. Louis, 1958, p. 272. 5. Dascomb, H. E.: in Current Therapy, Saunders, Phila., 1958, p.78. 6. Bickerman, H. A.: in Drugs of Choice, Mosby, St. Louis, 1958, p.547.

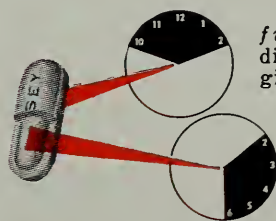
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then—the inner core releases its ingredients to sustain relief for 3 to 4 more hours

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In Memoriam . . .

John P. Anderson, M. D., Cleveland; University of Toronto Faculty of Medicine, Canada, 1920; aged 62; died September 5; member of the Ohio State Medical Association, the American Medical Association, American College of Physicians and the American College of Chest Physicians; diplomate of the American Board of Internal Medicine. A native of Canada, Dr. Anderson moved to Cleveland early in his career. He was associated with the Cleveland Clinic from 1923 to 1931, after which he was in private practice. Surviving are his widow, a daughter, a son, two brothers and a sister.

Richard A. Bolt, M. D., Berkeley, Calif.; University of Michigan Medical School, 1906; aged 79; died August 14; former member of the Ohio State Medical Association. A former practitioner in Cleveland, Dr. Bolt was associated with Western Reserve University School of Medicine and was director of the Cleveland Child Health Association. He left Cleveland in 1945 and went to California where he was director of health centers for Alameda County and medical director of schools in Oakland and Berkeley. Survivors include his widow, two daughters, two sons and a brother.

Galen F. Bowman, M. D., Toledo; Northwestern University Medical School, 1911; aged 72; died September 1 in a traffic accident; member of the Ohio State Medical Association and the American Medical Association. A practicing physician in Toledo for 47 years, Dr. Bowman was a veteran of World War I and a member of the American Legion. Other affiliations included memberships in several Masonic bodies, the Presbyterian Church and the local Trout Club. Surviving are his widow, and two daughters.

Guy E. Byers, M. D., Salem; Western Reserve University School of Medicine, Cleveland, 1918; aged 68; died August 21; member of the Ohio State Medical Association and the American Medical Association. Dr. Byers was a practicing physician in Salem and vicinity for 38 years, moving there in 1921. A veteran of World War I, he was active in a number of local organizations; was past-president of the local Rotary Club and the Columbiana County Public Health League. He was a member of the Methodist Church and the Masonic Lodge and formerly served on the city board of health. Surviving are his widow, a daughter, two sons and a sister.

Hans F. J. Cohn, M. D., Cleveland; Friedrich Wilhelms University Faculty of Medicine, Berlin, 1914; aged 72; died September 2. Dr. Cohn moved to Cleveland in 1941 and was in practice there. He is survived by his widow, Dr. Irma Cohn and a son, Dr. Peter Cohn, an intern at Mt. Sinai Hospital in Cleveland.


Charles W. Holtzmuller, M. D., Farmersville; Eclectic Medical College, Cincinnati, 1899; aged 86; died August 13; member of the Ohio State Medical Association and the American Medical Association. A practicing physician in the Farmersville area for virtually all of his professional career, Dr. Holtzmuller was a recipient of the OSMA 50-Year Award. He was a member of the Odd Fellows Lodge and was interested in several local business firms. Survivors include his wife by a second marriage, and two sons, one of whom is Dr. J. F. Holtzmuller, of Defiance.

Elmer E. Kirkwood, M. D., Youngstown; St. Louis University School of Medicine, 1919; aged 65; died August 14; member of the Ohio State Medical Association, the American Medical Association, the American College of Chest Physicians and the American Academy of General Practice. Dr. Kirkwood was head of the Mahoning Tuberculosis Sanatorium from 1925 to 1946 and later was in private practice in Youngstown. A veteran of World War I, he was a member of the Odd Fellows, Masons and the Methodist Church. Survivors are his widow and three sisters.

Karl J. Kraus, M. D., Las Vegas, Nevada; University of Cincinnati College of Medicine, 1934; aged 51; died August 5. Dr. Kraus moved to Nevada about 20 years ago. He is survived by his widow, two daughters, a son, two brothers and five sisters.

R. V. Myers, M. D., Mansfield; Western Reserve University School of Medicine, 1909; aged 79; died August 20; member of the Ohio State Medical Association and the American Medical Association. Dr. Myers practiced for many years in Mansfield. One of his interests was music and he was one of the founders of the Mansfield Symphony Orchestra. His widow survives.

Harry G. Pamment, M. D., Toledo; Rush Medical College, 1913; aged 74; died August 16; member of the Ohio State Medical Association and the American Medical Association. Dr. Pamment practiced medicine for some 40 years in



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Toledo and for 25 years was part-time epidemiologist for the local health department. His widow survives.

Gerard B. Robinson, M. D., Mount Gilead; Yale University School of Medicine, 1924; aged 61; died September 3 in an airplane crash. Dr. Robinson was a practicing physician for many years in Mount Gilead. He was a past-president of the Kiwanis Club and a member of several Masonic bodies. Surviving are his widow, two sons, a daughter, three sisters and a brother.

Ellis J. Smith, M. D., Cincinnati; Eclectic Medical College, Cincinnati, 1925; aged 59; died August 8; member of the Ohio State Medical Association and the American Medical Association. A native of Waynesville, Dr. Smith practiced for many years in Cincinnati. He is survived by his widow, three brothers and two sisters.

Hometown Prescription Program Of VA Still In Effect

The Veterans Administration "Hometown Prescription Program," started in 1946, still is in effect and physicians who take care of disabled veterans should utilize their hometown pharmacies whenever possible, according to a statement issued by M. Eugene Schafer, North Canton, president of the Ohio State Pharmaceutical Association.

Schafer's statement, reading in part as follows, was issued to clear up a misunderstanding to the effect that the hometown prescription program had been discontinued:

"The program was established to permit the veteran his choice of pharmacy and to make the latest drugs available to physicians and veterans in their own areas without having to use government facilities," stated Schafer. "The VA 'Hometown' program, though not a big program dollar-wise, nevertheless is an important one, since it reaffirms a basic belief that medical care, as much as practicable, should be handled by private persons and not by the government.

"Further," said Schafer, "the present program guarantees the veteran and his attending physician an accessible and complete stock of the latest and standard drugs and avoids unnecessary delay, inconvenience and waste. Pharmacists all use the pricing schedule which is stipulated by the government. We urge the medical practitioners who participate in the program to use their 'hometown' pharmacists and to inform the veterans they treat that they may have their Rx's filled at their own pharmacy.

Ten Veterans Administration hospitals are participating in a study to determine the effectiveness of certain hormones in treatment of tuberculosis.

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100 mg./2 cc. ampules

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Cosa-Terramycin is also available as:

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Do You Know?...

Dr. Thomas A. Dooley, the Laos physician, author and lecturer, who has many friends among Ohio physicians, recently underwent surgery for removal of a malignant lung tumor—a melanoma.

* * *

The American Hospital Association will place on its list of acceptable hospitals a hospital which permits osteopaths to work in the institution providing they work under the general supervision of doctors of medicine.

* * *

For the first time in the State's history, Ohio's Family Doctor Week was officially proclaimed by Governor DiSalle for September 14-19, 1959. Present with the Governor when the proclamation was issued were Charles R. Marlowe, president of the Ohio Academy of General Practice; Lewis Cellio, Columbus, president-elect of the Academy; and Dr. Joseph Lindner, Cincinnati, OAGP's first president.

* * *

The Cleveland Health Museum and the Cleveland Academy of Medicine jointly sponsored a Physician's Hobby Show September 5 through 27. More than 70 physicians displayed hundreds of items, ranging from ham radios to famous books. The show emphasized to the public the importance of hobbies to mental health.

* * *

Dr. William N. Hubbard, Jr., associate dean of the New York University College of Medicine, New York City, has been appointed dean of the University of Michigan Medical School, Ann Arbor, succeeding Dr. Albert C. Furstenberg, who has headed the Medical School since 1935.

* * *

Secretary of Health, Education and Welfare, Arthur S. Flemming, has announced the appointment of Dr. John L. Caughey, associate dean, College of Medicine, Western Reserve University, Cleveland, to a four year term as a member of the National Advisory Council on Rehabilitation.

* * *

Dr. Gunnar Gundersen, immediate Past-President of the American Medical Association, has accepted membership on the Medical Advisory Committee of the National Disease and Therapeutic Index, medical statistical research program.

* * *

James B. Hall, formerly assistant executive director of the Ohio State Heart Association, is the new executive director of the Heart Association of Greater Cincinnati.

Sixth District Postgraduate Day To Be in Warren, October 21

The program for the Sixth Councilor District Postgraduate Day has been announced. The place is the Packard Music Hall, Warren; the date, Wednesday, October 21, with registration opening at 8 a. m.

Several programs in the various branches of practice will be conducted concurrently so that physicians may choose the sessions which they wish to attend. The program follows:

8:45 - 9:15 a. m.

Cineclinic—Technique for Hemorrhoidectomy.

9:30 - 10:40

Medical—Newer Chemotherapeutic Agents in Management of Leukemia and Lymphomas, Dr. B. K. Wiseman, professor of medicine, Ohio State University.

Surgical—Diverticulosis-Diverticulitis, Dr. Ralph F. Bowers, moderator, chief of surgery, Kennedy Veterans Administration Hospital, Memphis, Tenn.; Dr. Henry Doubilet, associate professor of surgery, New York University College of Medicine; Dr. H. E. MacMahon, professor of pathology, Tufts University.

Pediatrics—Parenteral Fluid Therapy, Dr. Gordon Manson, moderator, associate physician, Department of Pediatrics, Henry Ford Hospital; Dr. Nicholas M. Stahl, former associate surgeon, Children's Hospital, Boston.

Obstetrics-Gynecology — Menstrual Disorders with Emphasis on Their Management, Dr. S. Leon Israel, moderator, associate professor of gynecology and obstetrics, University of Pennsylvania Graduate School of Medicine; Dr. Abraham F. Lash, clinical professor of obstetrics and gynecology, University of Illinois; Dr. Edward C. Mann, Department of Obstetrics and Gynecology, New York Hospital.

Medical-Surgical—Peripheral Vascular Disease, Arterial, Dr. Victor DeWolfe, moderator, Department of Internal Medicine, Cleveland Clinic; Dr. John J. McCaughan, Jr., Department of Vascular Surgery, Kennedy VA Hospital.

11:00 - 12:10

Medical and Surgical—Pancreatitis-Medical and Surgical Aspects, Dr. Henry Doubilet, moderator; Dr. Ralph Bowers, and Dr. Charles H. Brown, Department of Gastroenterology, Cleveland Clinic.

Orthopedic—Fractures of Hand, Forearm and Foot, Dr. Wallace Duncan, moderator, sen-

(Continued on Next Page)

(Sixth District Program—Cont'd)

ior associate surgeon, Department of Orthopedic Surgery, St. Luke's Hospital, Cleveland; Dr. Elden C. Weckesser, assistant clinical professor of surgery, Western Reserve University.

Pediatrics—Recurrent Vague Abdominal Pain in Childhood, Dr. Nicholas M. Stahl, moderator; Dr. Gordon Manson; Dr. Ronald L. Denton, associate professor of pediatrics, McGill University.

Obstetrics and Gynecology—Incomplete Cervical Os, Dr. Abraham F. Lash, moderator; Dr. S. Leon Israel, Dr. Edward C. Mann.

1:00 - 1:30

Cineclinic—Hospital Infections.

1:45 - 2:45

Medical — Problems of Pyelonephritis, Dr. Joseph M. Hayman, Jr., dean and professor of medicine, Tufts University College of Medicine; Dr. H. E. MacMahon.

Pediatrics — Hyperbilirubinemia of the Newborn, Dr. Ronald L. Denton.

Orthopedic—Fractures of the Femoral Neck, Dr. George O. Eaton, assistant professor of orthopedic surgery, Johns Hopkins University.

Surgical—Peripheral Vascular Disease, Venous, Dr. John J. McCaughan, moderator, Dr. Victor DeWolfe.

Obstetrics and Gynecology—Newer Concepts of Analgesia and Anesthesia in Obstetrics and Gynecology, Dr. Robert A. Hingson, moderator; Dr. Abraham Lash, Dr. S. Leon Israel and Dr. Edward C. Mann.

3:00 - 4:00

Medical—Failing Lung of Middle and Old Age, Dr. Edwin R. Levine, assistant clinical professor of medicine, Chicago Medical School.

Surgical—Hope for the Metastatic Carcinoma Patient, Dr. Michael J. Brennan, moderator, director of oncology, Henry Ford Hospital; Dr. Ralph Bowers, and Dr. Nicholas Stahl.

Obstetrics and Gynecology—The Complicated Pregnancy, Effect on Mother and Child, Dr. Edward Mann, moderator; Dr. Gordon Manson, Dr. Ronald Denton, Dr. Leon Israel and Dr. Abraham Lash.

4:10 - 5:10

Clinical Pathological Conference, Dr. MacMahon, moderator; Drs. Bowers, Doubilet, Wiseman and Hayman.

Following the program a reception will be held from 5:30 to 6:45 with dinner at 7:00. Speaker will be David Doyle of New York City.

First National Conference on Medical Aspects of Sports

The first national Conference on the Medical Aspects of Sports, sponsored by the American Medical Association, will be held Monday, November 30, in Dallas, Texas.

The one-day meeting is for college and high school athletic directors, coaches, trainers, and doctors. Dr. Allan J. Ryan, Meriden, Conn., chairman of the AMA Committee on the Medical Aspects of Sports, pointed out that the conference will deal with a wide variety of medical subjects which affect the athlete's total well being. These include training, conditioning, prevention and treatment of injuries, and the physiology of exercise.

Highlights of the program will be panel discussions of on-field responsibilities of the team physician and prevention of head injuries in athletics. Other discussions will concern amphetamines and the attitudes of athletes; a medical program for high school football; exercise and the oxygen debt; the biodynamic potential of the American male; exercise and the kidney, and the pathology of trauma.

The national Conference on the Medical Aspects of Sports will precede the clinical meeting of the AMA, which begins Dec. 1 in Dallas and continues for four days.

Mansfield Poison Information Center Added to 24-Hour Service List

In accordance with a recent action of the Committee on Poison Control of the Ohio State Medical Association, the Mansfield Poison Center will be added to the listing of poison information centers which appears each month in *The Ohio State Medical Journal* (See page 1405 for the complete list).

The center is located in the Emergency Room of the Mansfield General Hospital, 335 Glessner Avenue, Mansfield. The telephone number is LA 2-3411, Extension 248.

The center will give 24-hours a day service to physicians only, and will utilize a four-man resident staff, one on call each 24-hours. The National Clearing House file card system; various books on poisoning; and treatment and antidote facilities constitute the center's equipment.

Dr. George W. Loesch is chairman of the committee administering the center. Assisting him are Dr. Harry Wain, Richland County Health Commissioner; Dr. Larry C. Thompson; David Ott, Registered Pharmacist; and Philip Wisdon, assistant administrator of the hospital. All are of Mansfield.

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equivalent to 4 to 6 Gms. daily of previous
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1. Editorial, New England J. Med. 258:48, 1958.
2. Vinnicombe, J.: Antibiotic Med & Clin. Ther. 5:474, 1958.
3. Sheth, U. K., et al.: Ibid., p. 604, 1958.

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Activities of County Societies . . .

BELMONT

The Belmont County Medical Society and Auxiliary met on September 17 for a program and dinner at the Belmont Hills Country Club.

FAIRFIELD

Members of the Fairfield County Medical Society were guests of Dr. E. B. Roller for a noon luncheon on August 4 in the Wagnalls Memorial, Lithopolis. The Woman's Society of the Lithopolis Methodist Church served the meal.

GREENE

Mrs. Richard Downing is the new executive secretary of the Greene County Medical Society. Her address is 734 N. Monroe Drive, Xenia.

HAMILTON

The Annual Meeting of the Academy of Medicine of Cincinnati was held on September 22 in the Sheraton Gibson Hotel. Installation of officers for the coming year was a highlight of the program.

Guest speaker for the occasion was Dr. Joseph W. Ferrebee, research physician at Mary Imogene Bassett Hospital, Cooperstown, N. Y., and associate clinical professor of medicine at Columbia University.

Subjects and speakers for regular monthly meetings in the near future are:

October 20—"Resistant Infections," Dr. Ivan L. Bennett, Jr., Bexley Professor of Pathology, Johns Hopkins University.

November 17—"The Treatment of Cardiac Arrest," Dr. Henry Swan, II, professor of surgery and head of the Department, University of Colorado School of Medicine.

December 15—"Clinical Studies on the Adrenal Cortex," Dr. George W. Thorn, Hersey Professor of Theory and Practice of Physic, Harvard Medical School.

LORAIN

The largest number ever recorded, attended the joint meeting of Lorain County Medical Society and The Woman's Auxiliary on September 15, at Oberlin Inn, with 143 persons on hand to hear Dr. Robert S. Hingson, chief of anesthesia at Western Reserve University School of Medicine.

Dr. Hingson, with five other physicians and 10 other persons carried through "Project Brother's Keeper" during the summer and early fall of 1958—visiting countries in Asia and Africa, surveying medical facilities and needs, and assisting with public health programs, clinics and surgery. His lecture was most challenging and the pictures vividly illustrated the poverty and disease of vast areas in these continents.

Dr. Denis A. Radefeld conducted a very brief business meeting following the program and Drs. R. P. Hardwig and Boyd N. Park were elected to Associate Membership in the Society.

Dr. and Mrs. O. H. Schettler made available their garden for the Social hour prior to the dinner.—Lawrence C. Meredith, M. D., Secretary-Treasurer.

LUCAS

The Academy of Medicine of Toledo is co-sponsor with the city health department of the well-oldster program. The well-oldster program was started in March and is open to all Toledoans over 65 who are not ill.

The *Toledo Times* in a feature article described eligibility as follows: "Any eligible person interested in participating may contact the health department to make appointments for three visits there within one week. The visits include interviews, consultations and physical examinations. Four persons are processed each week, and so far 58 have participated in the program."

MIAMI

Subject for the September 4 meeting of the Miami County Medical Society was "Medical Economics." The speaker was Dan Parabeck, Lancaster, who is an associate of Professional Management, Inc.

MONTGOMERY

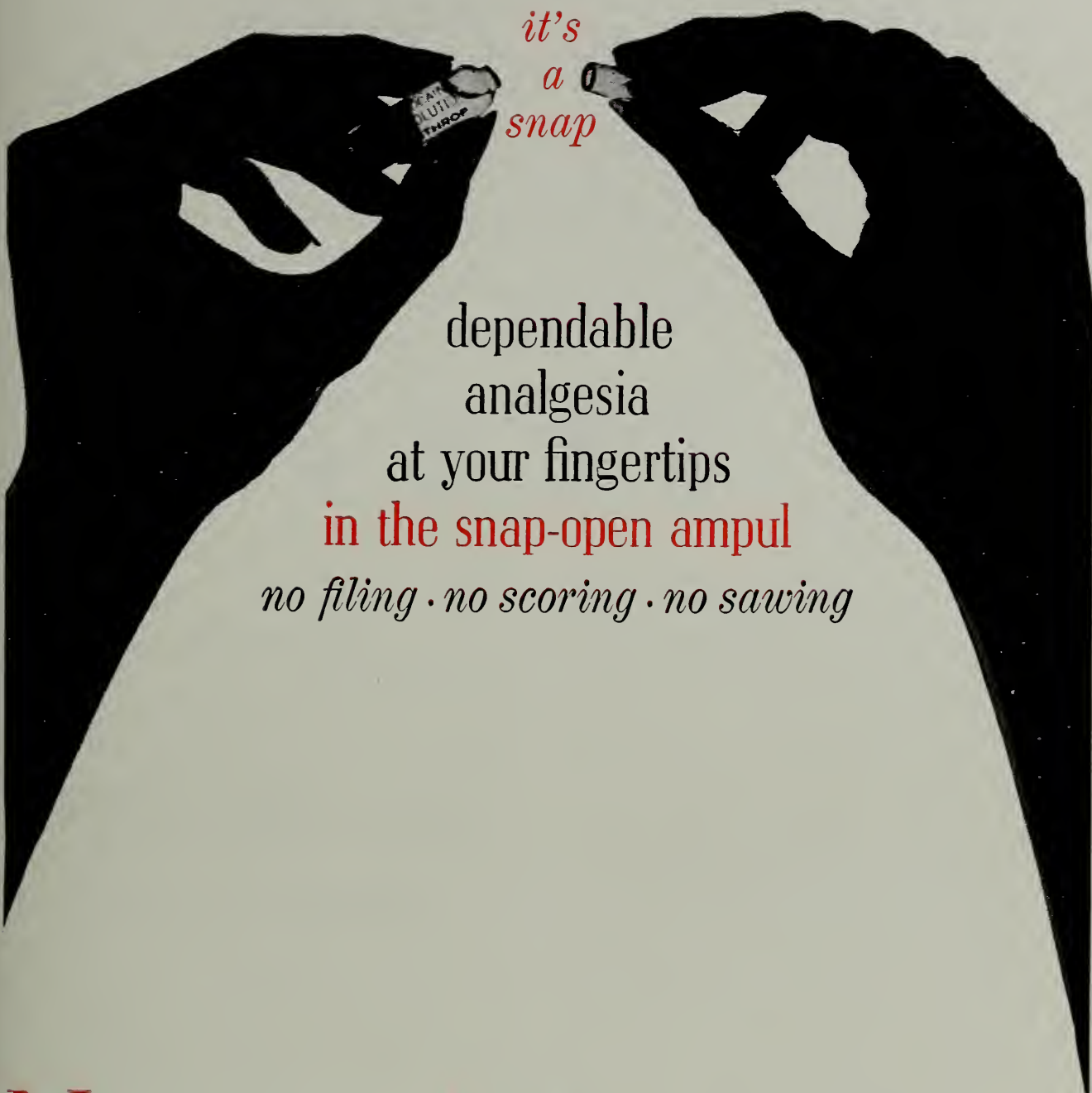
The Montgomery County Medical Society sponsored the third annual Athletic Injury Conference on September 1.

SCIOTO

Dr. A. W. Humphries, Department of Surgery, Cleveland Clinic, was guest speaker at the September 14 meeting of the Scioto County Medical Society in Portsmouth. His subject was "Low Back Pain and a New Method of Treatment by Anterior Spine Fusions."

Tax Decision Benefits Physicians

Another Federal court decision (Dallas, Texas) was handed down recently, conforming to a Federal court decision of 1954 (Kintner case) which holds that physicians practicing in a group as an unincorporated association should be taxed only on the salary and bonuses paid to them and not on association profits; that the association's undistributed profits should be taxed as are the undistributed profits of a corporation. This allows physicians to organize associations rather than partnerships and have all the benefits of corporations under the Federal Income Tax Law.



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OSMA Physicians, Staff Attend 1959 AMA PR Institute

Two OSMA physicians were among the speakers and two OSMA staff members were honored at the 1959 AMA Public Relations Institute in Chicago August 19-21.

Dr. Paul L. Weygandt, Akron, chairman, Summit County Medical Society Traffic Safety Committee and a member of the OSMA Traffic Safety Committee, spoke on the role of his committee in the Akron Traffic Violators' School, at which physicians lecture on auto injuries and related subjects before traffic violators required by the courts to attend the school.

Dr. Robert J. Murphy, Columbus, co-chairman of the Columbus Academy of Medicine Health Fair last spring, described the planning, organization and success of the fair, which drew more than 110,000 persons.

OSMA Executive Secretary Charles S. Nelson and George H. Saville, assistant executive secretary and director of public relations, were presented AMA citations "for * * * dedicated service and valuable counsel as a member of the Advisory Committee to the Director of the Communications (and Public Relations) Division of the American Medical Association."

Mr. Nelson served from 1951 to 1954, Mr. Saville from 1956 to 1959, and both served as committee chairmen.

Also attending were Dr. H. T. Pease, Wadsworth, Eleventh District Councilor; Dr. R. Dean Dooley, Columbus, director of professional relations for Ohio Medical Indemnity and former Second District Councilor; Dr. J. Robert Hudson, president, Cincinnati Academy of Medicine, and Dr. Lewis S. Shensa, Youngstown, chairman of the Mahoning County Medical Society Public Relations Committee.

Also, Executive Secretaries Edward F. Willenborg of the Cincinnati Academy of Medicine, Robert F. Freeman of the Montgomery County Medical Society and Howard C. Rempes, Jr., of the Mahoning County Medical Society; Hart F. Page, OSMA assistant director of public relations, and Charles W. Edgar, administrative assistant.

A one-day meeting of the Medical Society Executives Association preceded the public relations conference.

The PR Institute covered such subjects as legislation, science fairs and medical careers, community health and public relations projects, medical care costs, insurance costs, and concluded with problem-solving clinics in radio-TV-press relations, field service, aging, school health and legislation.

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Prosthetic and Orthotic
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Chicago Medical Society

March 1, 2, 3 and 4, 1960
Palmer House, Chicago

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Lectures

Teaching Demonstrations

Medical Color Telecasts

Instruction Courses
•

THE CHICAGO MEDICAL SOCIETY
ANNUAL CLINICAL CONFERENCE
should be a MUST on the calendar of every
physician. Plan now to attend and make
your reservation at the Palmer House.

- Exhibits unusual analgesic properties, different from those of any other drug
- Specific and superior in relief of SOMATIC pain
- Modifies central perception of pain without abolishing natural defense reflexes
- Relaxes abnormal tension of skeletal muscle

SOMATM

N-isopropyl-2-methyl-2-propyl-1, 3-propanediol dicarbamate

- More specific than salicylates
- Less drastic than steroids
- More effective than muscle relaxants

SOMA has an unique analgesic action. It apparently modifies central pain perception without abolishing peripheral pain reflexes. **SOMA** is particularly effective in relieving joint pain. Patients say that they feel better and sleep better with **SOMA** than with previously used analgesic, sedative or relaxant drugs.

SOMA also relaxes muscle hypertonia, with its stresses on related joints, ligaments and skeletal structures.

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Activities of Woman's Auxiliary . . .

CHAIRMAN PUBLICITY COMMITTEE—Mrs. W. J. Horger,
1100 Ohio Ave., East Liverpool, Ohio
(See Page 1322 for roster of officers.)

CUYAHOGA

The new President of the Woman's Auxiliary to the Academy of Medicine of Cleveland, Mrs. Frank Meany, presided at the Executive Board Meeting held at the Cleveland Yacht Club. Mrs. Meany introduced the following committee chairmen for the 1959-60 season.

Mrs. J. Kenneth Potter, AMEF Christmas card project, Mrs. J. A. Crowley, co-chairman; Mrs. Russell Rizzo, Sympathy & "In Appreciation" cards for AMEF; Mrs. H. C. Konys, Auxiliary News advertising; Mrs. J. F. Corsaro, East Side Bowling; Mrs. J. H. Budd, West Side Bowling; Mrs. J. F. Corsaro, Chrysanthemum Ball, Mrs. H. A. Haller, co-chairman; Mrs. R. E. Hannon, Finance; Mrs. F. M. Freimann, Civil Defense; Mrs. C. A. Obert, Hospitality; Mrs. J. L. Faragher, Legislation;

Mrs. E. Marshall, Mailing; Mrs. J. R. O'Malley, Para-Medical Careers; Mrs. C. C. Althoff, East Side Membership, Mrs. James Winkler, co-chairman; Mrs. F. P. Geraci, West Side Membership, Mrs. E. F. Kotershall, Mrs. L. J. Sternicki, co-chairmen; Mrs. W. F. Boukalik, Mental Health; Mrs. E. F. Kieger, co-chairman; Mrs. R. J. Kennedy, Nurses' Awards, Mrs. G. G. Bassett, co-chairman; Mrs. R. B. Turnbull, Nurses Recruitment-Blood Donors; Mrs. J. N. Wychgel, Parliamentarian.

Mrs. H. H. Peveroff, Program; Mrs. William Hegarty & Mrs. Gilbert Dickerhoof, Publicity; Mrs. C. H. Reinacher, Community Service; Mrs. J. D. Vande Velde, Radio & Television; Mrs. D. G. Gillespie, Safety; Mrs. M. Hill, Telephone; Mrs. Arthur Watkins, *Today's Health*; Mrs. Myron Perkuch, "Wife Line" Columnist for the Academy Bulletin; Mrs. G. E. Gessler, Convention chairman, Mrs. F. R. Rittinger, co-chairman; Mrs. G. E. Gustafson, Medical Samples.

The President announced the following events:

1959—September 15-16, Fall Conference, Lincoln Lodge, Columbus; September 24, Fifth District Meeting, College Club; October 9, Membership Tea, Clifton Club; November 7, Chrysanthemum Ball, Carter Hotel.

1960—February 8, Nurses' Award Luncheon, Higbee's Auditorium; May 16-19, Ohio State Medical Ass'n. Convention, Sheraton Cleveland Hotel; May 20, Annual Academy of Medicine Meeting Auxiliary Skit, Severance Hall; June 2, Annual Auxiliary Meeting, College Club.

Important matters acted upon at this Board Meeting Included: Arrangements to furnish six drivers for half days to pick up couriers and collect money from specific points during the United Appeal Campaign, October 19 through November 2, 1959; Action to comply with a request from Dr. Ferrari, President of the Academy of Medicine that the Auxiliary give support to the Poison Center, now in operation, and co-operation from the group when the Center is turned over exclusively to the Academy in 1960. Proceeds from the Chrysanthemum Ball in November will be donated to the Poison Center, if approved by the Executive Board of the Academy of Medicine.



Another new project has been launched by the Auxiliary to the Cleveland Academy of Medicine headed by Mrs. G. E. Gustafson. Auxiliary members have been asked to remind their husbands to take the drug samples, which they do not need, to the central collection point at the Cleveland Academy of Medicine, 2009 Adelbert Road. (Wives are to make this little trip themselves if their doctor husbands are too busy.) These drug samples, (such as vitamins, sedatives, etc.) are being distributed to local charitable organizations and the remainder is being sent abroad. Arrangements are being made with the Medical Assistants Society to help get these samples to the Academy of Medicine so they may be utilized before their expiration dates.

HAMILTON

Mrs. George B. Haydon, the retiring chairman of the philanthropic fund of the Woman's Auxiliary to the Academy of Medicine of Cincinnati, recently announced the winner of the \$500.00 scholarship to the College of Nursing and Health of the University of Cincinnati. The young lady is Miss Carole Ann Strattman, daughter of Mr. and Mrs. Walter Strattman of Cincinnati. Carole Ann graduated from Colerian Township High School, where she was a member of the Health Careers Club, which is sponsored by the Woman's Auxiliary to the Academy of Medicine of Cincinnati. Mrs. Carl Schilling, chairman of the Health Careers Clubs and Mrs. John Toelfer, her co-chairman and their committee, conduct seventeen of these clubs in the high schools in Hamilton County. The purpose of these clubs is to promote interest in health careers.

A \$200.00 award was also given. The recipient of it was Miss Mary Ann Alexander, daughter of Mr. and Mrs. Claude Alexander, of Cincinnati. Miss Alexander is a junior student in the



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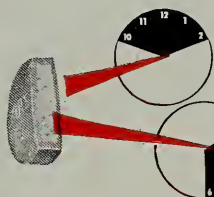
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- in postnasal drip
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Relief with Triaminic is prompt and prolonged because of this special timed-release action... beneficial effect starts in minutes, lasts for hours



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Phenylpropanolamine HCl50 mg.
Pheniramine maleate25 mg.
Pyriminamine maleate25 mg.

One-half of this formula is in the outer layer, the other half is in the core.

Dosage: One tablet in the morning, mid-afternoon and at bedtime.

References: 1. Lhotka, F. M.: Illinois M. J. 112: 259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

TRIAMINIC JUVELETS: Each timed-release Juvelet is equivalent in formula and dosage to one-half of a TRIAMINIC tablet, for the adult or child who requires only half strength dosage.

TRIAMINIC SYRUP is recommended for adults and children who prefer liquid medication. Each 5 ml. tsp. is equivalent to $\frac{1}{4}$ of a Triaminic Tablet. *Adults:* 2 tsp. 3-4 times a day; *children 6-12:* 1 tsp. 3-4 times a day; *children under 6:* in proportion.

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College of Nursing and Health of the University of Cincinnati.

The proceeds of the scholarships were derived from the annual Christmas dance sponsored by the Woman's Auxiliary to the Academy of Medicine of Cincinnati.

LUCAS

Under the new president, Mrs. George H. Lemon, the auxiliary's first project, and a very important public relations one, was the Health Exhibit at the Lucas County fair in August. Mrs. Charles R. Marlowe, chairman, and Mrs. H. W. Honeck, co-chairman, along with 30 auxiliary members planned most attractive booths where distribution was made of free pamphlets regarding civil defense, mental health, cancer, AMEF, heart disease, poisoning, polio, and the league of hard of hearing. Student nurses in uniform from the local hospitals were present to answer questions pertaining to nursing and allied careers.

Congress on Allergy

American College of Allergists Graduate Instructional Course and Annual Congress will be held February 28 to March 4, 1960, The Americana Hotel, Bal Harbour, Miami Beach, Florida. For information contact John D. Gillaspie, M. D., Treasurer, 2049 Broadway, Boulder, Colorado.

New Members of OSMA

The following are the names of the new members of the Ohio State Medical Association since August 1, 1959. The list shows the county in which they are affiliated, city in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

Cuyahoga County

Thomas L. Crawford, Cleveland
Galina B. Hrushchov, Cleveland
Richard M. Iammarino, Cleveland
George D. Kanellos, Cleveland
Layton M. Kest, Cleveland
Philip A. Khairallah, Cleveland
Michael Kulick, Cleveland
Robert R. Renner, Cleveland
Edward W. Schnell, North Olmsted
Joseph L. Toth, Cleveland

Franklin County

Edward A. John, Columbus

Hamilton County

Edward T. Buford, Jr., Cincinnati
John R. Cummings, Cincinnati
Cornelius E. Healy, Cincinnati
Richard H. Morris, Cincinnati

Joseph F. Possert, Cincinnati
Ernst G. Rolfes, Cincinnati
Louis L. Sommer, Cincinnati

Lucas County

Robert G. Sheperd, Toledo
Frank F. Snyder, Toledo
David P. Wheeler, Toledo

Montgomery County

Joseph M. Albrecht, Dayton
Wendell M. Burns, Dayton
James B. Evans, Dayton
Philip Goldberg, Dayton
Adrian R. Jensen, Dayton
Konrad Kircher, Dayton
Russell S. Zanowick, Miamisburg

Perry County

Robert W. Kramer, Jr., New Lexington

Seneca County

Anthony S. Lupica, Tiffin
Lynsky, James E., Tiffin
James A. Murray, Fostoria

Cook County Graduate School of Medicine

INTENSIVE POSTGRADUATE COURSES

STARTING DATES — FALL, 1959

SURGERY—Surgical Technic, two weeks, Oct. 19, Nov. 30. Surgery of the Colon & Rectum, one week, Oct. 26, Nov. 30. Gallbladder Surgery, three days, Nov. 2. Surgery of Hernia, three days, Nov. 5. General Surgery, one week, Oct. 26; two weeks, Dec. 7. Board of Surgery Review Course, Part I, two weeks, Oct. 5. Blood Vessel Surgery, one week, Nov. 30.

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, Oct. 19. Vaginal Approach to Pelvic Surgery, one week, Nov. 16. General & Surgical Obstetrics, two weeks, Nov. 2.

MEDICINE—Diseases of the Chest, one week, Nov. 2. Gastroscopy & Gastroenterology, two weeks, Nov. 2. Internal Medicine, two weeks, Oct. 19.

UROLOGY—Two-week intensive course, Oct. 26. Ten-Day Practical Course in Cystoscopy, by appointment.

RADIOLOGY—Diagnostic Radiology, two weeks, Nov. 30.

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REFERENCES: 1. Carpenter, E. B.: Southern M. J. 51:627, 1958. 2. Forsyth, H. F.: J.A.M.A. 167:163, 1958. 3. Lewis, W. B.: California Med. 90:26, 1959. 4. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:160, 1958. 5. Park, H. W.: J.A.M.A. 167:168, 1958. 6. Plumb, C. S.: Journal-Lancet 78:531, 1958.

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Academy of Psychosomatic Medicine, Sheraton-Cleveland Hotel, Cleveland, October 15-17.

American Medical Association, Clinical Session, Dallas, December 1-4.

American Association of Medical Assistants, Benjamin Franklin Hotel, Philadelphia, Pa., October 16-18.

American Heart Association, Annual Meeting and Scientific Sessions, Philadelphia, October 23-27.

Cleveland Academy of Medicine, Seminar on Recent Advances in Diagnosis and Therapy of Malignant Diseases, November 18-19.

Columbus Academy of Medicine, Clinic Day, October 21.

Eighth Councilor District, Meeting and Scientific Program, Lancaster, October 8.

Medical Society of the State of Pennsylvania, Penn-Sheraton Hotel, Pittsburgh, October 18-23.

Medical Technology Symposium, Bunts Institute of Cleveland Clinic, 2020 E. 93rd St., Cleveland, November 12-13.

Mid-West Conference, Central Rheumatism Society and Fourth Annual Session on Rheumatic Diseases, Ohio Union, OSU Campus, Columbus, October 18-19.

Northwestern Ohio Medical Association, Findlay Country Club, October 7, all-day session; registration 8:30 a.m.; first speaker, 9:45 a.m.

Second District Postgraduate Program, Springfield, October 21.

Sixth Councilor District Postgraduate Day, Warren, October 21.

Symposium on Therapy of Acute Injuries, AMA Council on Drugs, Cleveland, October 7.

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A new service to keep hospitals informed of developments in hospital planning, financing, design and construction has been inaugurated by the American Hospital Association. The Association will offer a Hospital Planning Abstract Service to provide a concise summary of what is appearing in journals, in reports or in other publications.

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MONROE—Byron Gillespie, Secretary, South Main Street, Woodsfield.

TUSCARAWAS—Chester A. Bennett, President, 533 Wooster Ave., Dover; George D. Woodward, Secretary, 201 Boulevard, Dover. 2nd Thursday, monthly.

EIGHTH DISTRICT

ATHENS—T. J. Najm, President, 422 W. Washington St., Nelsonville; Charles R. Hoskins, Secretary, Security Bank Bldg., Athens. 2nd Tuesday, monthly.

FAIRFIELD—Lloyd L. Kersell, President, 130 Union St., Lancaster; Arthur B. VanGundy, Secretary, 843 N. Columbus St., Lancaster. 2nd Tuesday, monthly.

GUERNSEY—Jesse B. Kellum, President, 840 Wheeling Ave., Cambridge; Thomas D. Swan, Secretary, 651 Wheeling Ave., Cambridge. 1st Thursday, monthly.

LICKING—Kurt J. Fleisch, President, 125 Hudson Ave., Newark; Jay Ross Wells, Secretary, 375 Granville St., Newark. Last Tuesday, monthly.

MORGAN—A. H. Whitacre, President, Chesterhill. Called meetings.

MUSKINGUM—J. Herbert Bain, President, 67 W. Main St., New Concord; William A. Knapp, Secretary, 1025 Maple Ave., Zanesville. 1st Tuesday, monthly.

NOBLE—Charles F. Thompson, President, Caldwell; E. G. Ditch, Secretary, Caldwell. 1st Tuesday, monthly.

PERRY—Charles E. Bope, President, Somerset; O. D. Ball, Secretary, 203 N. Main St., New Lexington. Called meetings.

WASHINGTON—William R. Stewart, President, 407 Second St., Marietta; Donald S. Williams, Secretary, 222 Third St., Marietta. 2nd Wednesday, monthly.

NINTH DISTRICT

GALLIA—Thomas W. Morgan, President, Holzer Hospital, Gallipolis; Norman W. Pinschmidt, Secretary, Gallipolis Clinic, 52 State Street, Gallipolis. 3rd Thursday, monthly.

HOCKING—George B. Watson, President, Box 296, Adelphi; Howard M. Boocks, Secretary, Court House, Logan. Indefinite meeting dates.

JACKSON—Tom Washam, President, 35 Vaughn St., Jackson; Brinton J. Allison, Secretary, 267 Ralph St., Jackson. Called meetings.

LAWRENCE—Gerard C. Geswein, President, 1626 S. Sixth St., Ironton; George Newton Spears, Secretary, 422 South Sixth Street, Ironton. Monthly meetings on call.

MEIGS—Charles J. Mullen, President, 210½ E. Main St., Pomeroy; Selim J. Blazewicz, Secretary, 112½ E. Main St., Pomeroy. Last Wednesday, monthly.

PIKE—Paul H. Jones, President, Stockdale; George W. Cooper, Secretary, Box 215, Picketon. 1st Tuesday, monthly.

SCIOTO—Ralph W. Lewis, President, 1025 Ninth St., Portsmouth; Carl H. Laestar, Secretary, 2829 Gallia St., Portsmouth. 2nd Monday, monthly.

VINTON—Richard E. Bullock, President, McArthur.

TENTH DISTRICT

DELAWARE—Max W. Livingston, President, 28 North Vernon, Sunbury; Edward C. Jenkins, Secretary, c/o Mrs. Mabel Barrett, Jane M. Case Hospital, Delaware. 3rd Tuesday, monthly.

(Continued on Next Page)

COUNTY SOCIETIES' OFFICERS AND MEETING DATES (Continued)

FAYETTE—H. Wm. Payton, President, 36 S. Main St., Jeffersonville; Marvin H. Roszmann, Secretary, 107 N. North St., Washington C. H. 2nd Tuesday, monthly.

FRANKLIN—James L. Henry, President, 244 E. Park St., Grove City; Mr. William Webb, Executive Secretary, 79 East State Street, Columbus 15. Meetings in January, February, March, May, September, November and December.

KNOX—Henry T. Lapp, President, 4 Public Square, Mt. Vernon; Thomas L. Bogardus, Secretary, 50 Public Square, Mt. Vernon. Quarterly meetings.

MADISON—William T. Bacon, President, 40 E. First St., London. 2nd Wednesday, monthly.

MORROW—Andrew Maciurak, President, 119 E. Main St., Cardington; William S. Deffinger, Secretary, Marengo. First Tuesday, monthly.

PICKAWAY—Henry H. Swope, President, 233 N. Court St., Circleville; Edward L. Montgomery, Secretary, 108 Seyfert Ave., Circleville. 1st Friday, monthly.

ROSS—Robert E. Quinn, President, 30 N. Walnut St., Chillicothe; G. Howard Wood, Secretary, 134 W. Main St., Chillicothe. 1st Thursday, monthly.

UNION—Paul R. Zaugg, President, 130 N. Maple St., Marysville; May B. Zaugg, Secretary, 130 N. Maple St., Marysville. 2nd Tuesday, monthly.

ELEVENTH DISTRICT

ASHLAND—R. Lee Schafer, President, 203 Maple Street, Ashland; Wayne C. Smith, Secretary, 1060 Claremont Ave., Ashland. 1st Friday, monthly, except July, August.

ERIE—Richard F. Hoffman, President, Providence Hospital, Sandusky; Edward P. Gillette, Jr., Secretary, 410 Columbus Ave., Sandusky. Monthly meeting date varies.

HOLMES—Clyde Bahler, President, Walnut Creek; Luther W. High, Secretary, R. F. D. 4, Millersburg. 2nd Wednesday, monthly.

HURON—Walter A. Drury, President, Box 269, Willard; John V. Emery, Secretary, Box 269, Willard. 2nd Wednesday, March, June, September and December.

LORAIN—Denis A. Radefeld, President, 209 Sixth St., Lorain; Mrs. C. Ruth Zealley, Executive Secretary, 311 Elyria Block, Elyria. 2nd Tuesday, monthly.

MEDINA—Robert E. Smith, President, 403 East Liberty St., Medina; William G. Halley, Secretary, 115 Bank Street, Lodi. 3rd Thursday, monthly.

RICHLAND—Riley E. Frush, President, 36 S. Mulberry St., Mansfield; James O. Ludwig, Secretary, 336 Sturges Ave., Mansfield. 3rd Thursday, monthly.

WAYNE—Ralph I. Cottle, President, 230 N. Market St., Wooster; Robert E. Schulz, Secretary, Wooster Community Hospital, Wooster. 2nd Wednesday, monthly.

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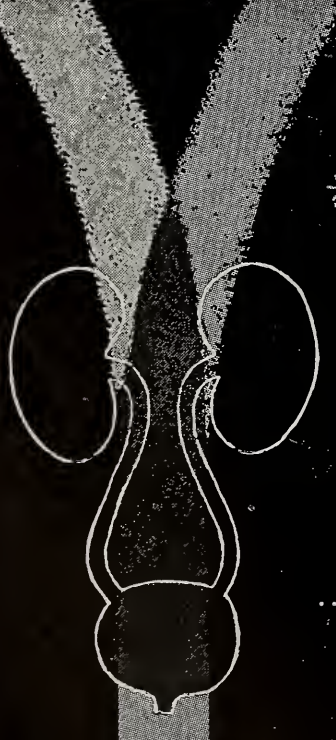
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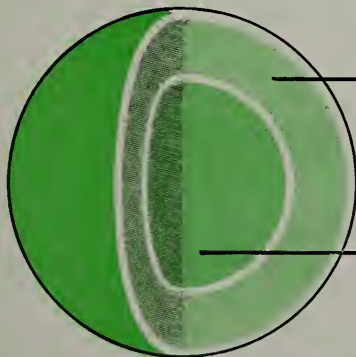
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the complaint: "nervous indigestion"

the diagnosis: any one of several nonspecific gastrointestinal disorders requiring relief of symptoms by sedative-antispasmodic action with concomitant digestive enzyme therapy.

the prescription: a new formulation, incorporating in a single tablet the actions of Donnatal and Entozyme. **the dosage:** two tablets three times a day, or as indicated.



the formula: in the gastric-soluble outer layer:

Hyoscyamine sulfate	0.0518 mg.
Atropine sulfate	0.0097 mg.
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Phenobarbital (1/8 gr.)	8.1 mg.
Pepsin, N.F.	150 mg.

in the enteric-coated core:

Pancreatin, N.F.	300 mg.
Bile salts	150 mg.

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Washington Roundup

News from the Nation's Capital of Interest to Physicians; Developments in Medical and Health Fields

Newly established Bureau of Retirement and Insurance in Civil Service Commission will administer Federal Employees Benefits Act which becomes effective July 1, 1960. Approximately two million Federal employees will be eligible. Government will contribute maximum of \$3.95 monthly for individual enrollees, \$9.55 for those with dependents. If total premium is less than \$5.60 for individuals and \$13.50 for family policy, government will pay 50 per cent of premium. Enrollees will have choice of service or indemnity program.

* * *

Federal Aviation Agency's statement that there is medical justification for compulsory retirement of pilots 60 years old and for refusing applicants past 55 certification to fly jet planes is disputed by Air Line Pilots Association. Pilots contend agency's stand is not supported by medical evidence, that there is no relationship between pilot's age and accident frequency, and that FAA lacks power to make such a ruling.

* * *

Senate Antitrust Committee has stated that forthcoming probe into manufacturers' prices of prescription drugs is not an attack on AMA, a probe of organized medicine or a plug for socialized medicine.

* * *

Medical Economist Eli Ginzberg, Ph. D., Columbia University, told Joint Economic Committee of Congress that increasing supply of doctors is not answer to U. S. health needs. He said at committee hearing on rising costs of professional services that "doctors equal health is a very foolish and incorrect equation." Saying health is not the sole or primary concern of doctors, he added that a population's income, eating habits, where it lives and how it is educated as well as how it takes care of itself all are important aspects of health.

* * *

National Institutes of Health Clinical Center has started intensive study of role of adrenal gland in Stein-Leventhal syndrome, and is asking cooperation of interested physicians. Referral letters or telephone calls should be directed to Dr.

J. F. Rall, chief, clinical endocrinology branch, National Institute of Arthritis and Metabolic Diseases, Bethesda 14, Md. Symptoms of condition include oligomenorrhea, hirsutism and polycystic ovaries.

* * *

Article in Social Security Bulletin (October issue) states in fiscal year ended June 30, 1958, about \$23 billion were spent for health and medical care, consisting of \$17.3 billion for private expenditures and \$5.5 billion in public expenditures. Report shows that since 1929 public expenditures rose from 14 per cent to 24 per cent of total outlay. Public funds purchased 10 per cent of personal health care in 1928-29, increasing to 18 per cent in 1957-58.

* * *

Pan American Health Organization is supporting proposed International Health and Medical Research Year. If World Health Assembly adopts proposal at its May, 1960 meeting, year of observance will be 1962 or 1963.

* * *

Surgeon General Burney reports Salk vaccine is in ample supply. Since April, 1955, release of vaccine, more than 68 million persons have received full immunization and 18 million obtained partial immunization. Of 1,446 paralytic cases where vaccine record is known, investigation showed that 83.7 per cent were not vaccinated or only partially vaccinated.

* * *

Internal Revenue Service ruling applying to persons attending medical and other meetings as delegates states, "A taxpayer who attends a convention or meeting as an appointed or elected delegate does not, merely because of that status, become entitled to deduct as business expenses the expenses incurred in connection with his attendance at such convention. In order to be deductible by him, the expenses must be incurred in carrying on the taxpayer's own trade or business activities as distinguished from those of another taxpayer or entity." IRS adds, however, that if it is undertaken for his own vocational gain, then it is held to be deductible, and it is deductible if he is attending to advance or benefit the interests of his profession or business.

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The Physician's Bookshelf

(Books received from publishers. *The Journal* is not obligated to list herein every book received. It will try to list those which appear to be of greatest interest.)

* * *

A Cookbook for Diabetics, by Deaconness Maude Behrman and edited by Leonard L. Levinson. (\$1.00, *American Diabetes Association* 1 E. 45th Street, New York 17, N. Y.) Backed by the authority of the American Diabetes Association, this cookbook is an excellent collection of recipes for the diabetic. It is clearly written and eminently practical. It is designed to provide the diabetic with an understanding of food preparation and with an interesting variety of meals. The menus are based upon the widely accepted exchange lists.

Notes of a Soviet Doctor, by G. S. Pondoev, M. D., translation by Iago Galdston, M. D. (\$4.95, Second edition, *Consultants Bureau, Inc.*, 227 W. 17th St., New York 11, N. Y.) A Russian who practiced medicine under the Czars and the Communists writes of medical conduct and ethics for Soviet medical students and young physicians. It has become a guidebook for conduct of Russian physicians. Readers will find of interest the constant threads of totalitarian philosophy woven throughout the writer's commentaries on the scientific facets and the humanistic side of medicine as practiced under the Russian system.

An Introduction to Public Health, by Harry S. Mustard, M. D., and Ernest L. Stebbins, M. D. (\$4.50, *The MacMillan Company*, New York 11, New York.) This fourth edition of a popular text provides students, physicians and interested laymen with a modern analysis of the public health field. It incorporates the most recent developments in public health practices, including expanded material on general medical care and chronic disease control. Its main purpose is to provide orientation in the public health field, excluding administration. It is informational and statistical, written toward giving the reader perspective and historical background.

Quantitative Methods in Human Pharmacology and Therapeutics, by D. R. Laurence, M. D. (\$7.50, Vol. 3, *Pergamon Press, Inc.*, New York 22, N. Y.) This is the third in a series of proceedings of the Coordinating Committee for Symposia on Drug Action, supported by the British Pharmacological Society, Physiological Society, Royal Society of Medicine, Biometric Society and the Nutrition Society. Purpose of the proceedings is to bring together workers and ideas

in fields in which there is a common interest in the accurate measurement of drug effects. Subjects covered include methods and problems associated with evaluation of drugs in man, newer statistical methods applicable to human pharmacology and therapeutics, and introduction of drugs into clinical practice and clinical trials. Participants were selected from persons in England, the United States, and Sweden known for their leadership in these fields.

Medicine and Anthropology, by Iago Galdston, M. D. (\$3.00, *International Universities Press*, New York 11, N. Y.) This is a compilation of six lectures covering such topics as the implications of magical beliefs on the acceptance and efficacy of medicine, medicine as it appears to the humanist, the problems posed for medical science by the differences in cultural mentality, etc.

The authors stress the needs to adapt medical practice to the cultural orientation of the patient and to view the patient as a whole individual within his social, cultural and economic context. Although the authors base their thesis upon the information obtained from much wider geographical and cultural experience, their concept of adaptation and orientation has a certain amount of practical application for those of us who are dealing with such situations as the backwoods mountaineer transplanted to an urban, industrialized society.

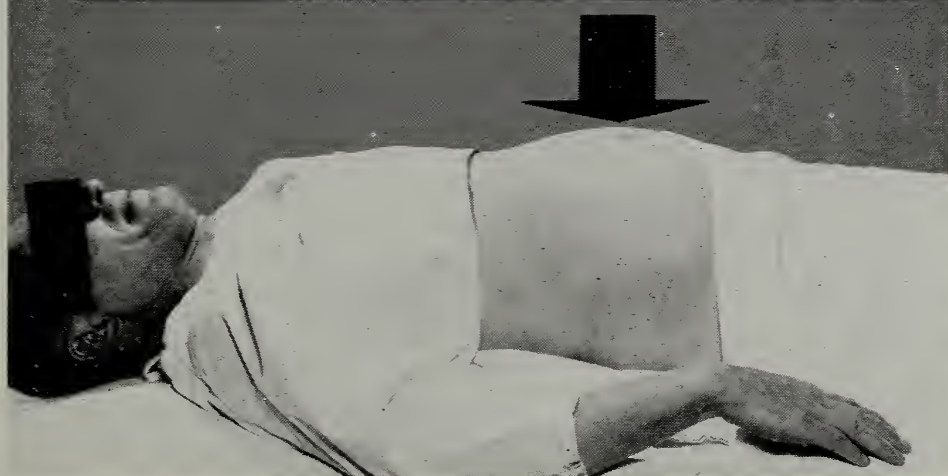
These essays make fascinating and instructive reading and are highly recommended.

Care of the Patient with a Stroke, by Genevieve W. Smith, R. N. (\$2.75, *Springer Publishing Company, Inc.*, New York 10, N. Y.) This is a very practical manual setting forth in detail solutions to the many problems facing the family and the nurse of a patient with a stroke. The handbook is well written and well illustrated and may be recommended with confidence to the families of such patients.

Antibiotics; Their Chemistry and Non-Medical Uses, by Herbert S. Goldberg, Ph. D. (\$15.00, *Van Nostrand Company, Inc.*, Princeton, New Jersey.)

The Pathology and Management of Portal Hypertension, by R. Milnes Walker, M. S. (\$8.00, *The Williams & Wilkins Company*, Baltimore 2, Maryland, exclusive U. S. agents.)

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to prevent...to relieve... post-op distention and ileus

Surgical stress appears to increase the body's pantothenic acid requirements. ILOPAN (d-pantothenyl alcohol, W-T) provides additional pantothenic acid to aid restoration of normal peristalsis. Clinical studies and hundreds of case histories^{1, 2} attest the effectiveness of ILOPAN against postoperative retention of flatus and feces — even paralytic ileus — and in reducing the need for intestinal intubation, or the period of intubation.

ILOPAN may be used with a high degree of safety — is not contraindicated even under conditions of mechanical bowel obstructions, produces no hyper-peristalsis or cramping, no side effects — and can be routinely administered by the nurse.

Supplied in:
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(250 mg.)
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1. Kareha, L. G., de Quevedo, N. G., Tighe, P., Kehrli, H. J., "Evaluation of Ilopan in Postoperative Abdominal Distention." *Western J. Surg. Obs. & Gyn.*, 66:220, 1958
2. Stone, M. L., Schlusell, S., Silberman, E., Mersheimer, W. L., "The Prophylaxis and Treatment of Postpartum and Postoperative Ileus with Pantothenyl Alcohol." *Amer. J. Surgery*, 97:191, 1958

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In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

TIME FOR CONTRIBUTION TO AMEF

Have you responded to the request you received recently from Dr. Prugh, Ohio AMEF chairman, to make your contribution to support the nation's medical schools? If not, don't delay any longer this opportunity to strike a blow for liberty in medical education.

As you know, the schools are having difficulty in meeting operating expenses. They must maintain high standards. If private support is not forthcoming, the alternative is Federal subsidy—and that inevitably means Federal control.

Last year nearly \$200,000—a record amount—was raised in Ohio for this worthy cause. Approximately one-half of the physicians of Ohio were donors either through AMEF or directly to the Alumni Funds of their medical schools.

Won't you make an investment in the future of medical education by sending in your contribution now? If you wish, earmark your gift for your own school. The address is: American Medical Education Foundation, 535 N. Dearborn St., Chicago, Ill.

SOME MORE ADVICE ON ENTERTAINMENT DEDUCTIONS

The Internal Revenue Service has issued some guide lines which can be followed by physicians in taking deductions for entertainment expenses—one of the headaches which have confronted physicians in making out their income tax returns. Whether they are for better or worse, at least they are criteria. Needless to say they should be observed.

As spelled out by the Internal Revenue Service a physician may deduct, for federal income tax purposes, the costs of entertaining other physicians and patients provided he can show that such entertainment produced business income.

An Internal Revenue Service ruling states "the clear relationship of the expenditure to reasonably expected income must be shown."

Deductions for repeated entertainment of an individual doctor since that "indicates a personal motive probably won't be allowed."

"The general statement that the physician hoped or expected to get referrals or patients as a result of the entertainment is not enough," IRS stated. "If personal reasons predominate, the

expenditure may not be deducted, even though there is some possibility of a business benefit."

Among the criteria to be used in establishing the deductibility of entertainment expenses are: Specific purpose of entertainment; percentage of the doctor's patients received as referrals; names of individuals entertained and reason why additional income could reasonably be expected from each; whether or not referrals were actually received from the doctors entertained; whether or not other doctors in the same type practice in the locality have entertainment expenses.

Physicians who intend to claim entertainment deductions certainly should keep a good set of books.

BUYER'S GUIDE TO HEALTH INSURANCE

One of the latest pamphlets of the AMA is a 16-page booklet entitled, "A Buyer's Guide to Voluntary Health Insurance." It is designed to help purchasers of health insurance have a better understanding of the coverage they have or are considering.

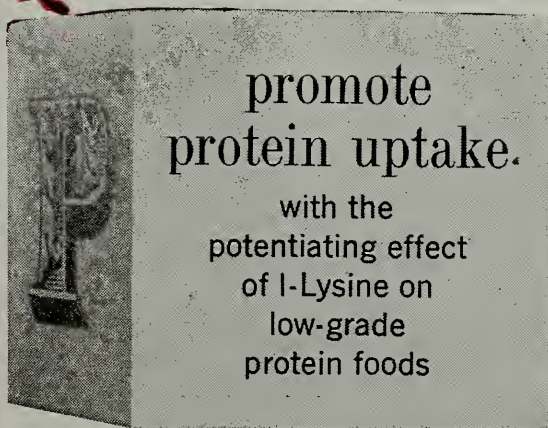
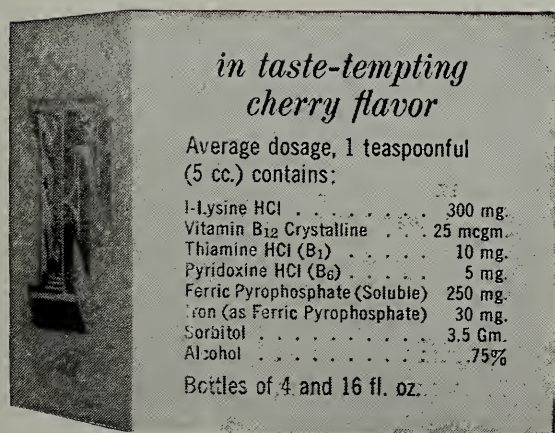
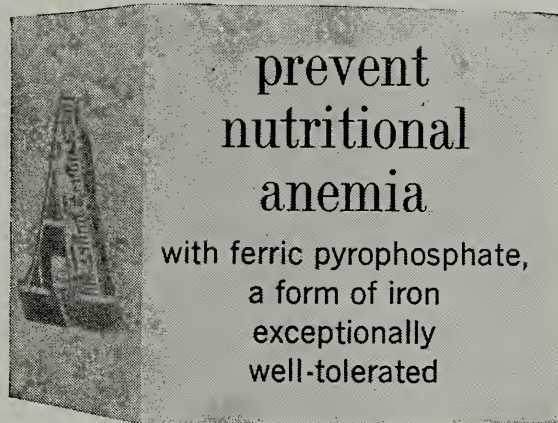
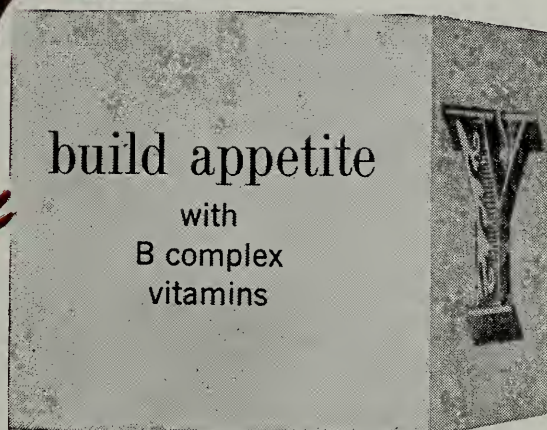
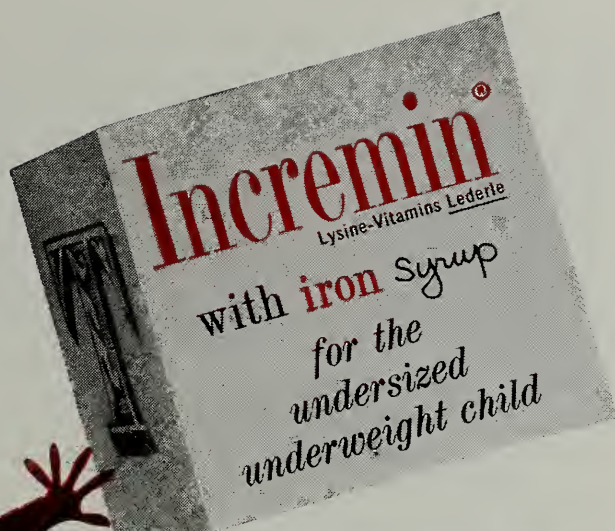
Some of the topics covered are: types of health care expenses; the extent of coverage; the underwriting organization; the contract, policy or agreement; contract provisions—insuring clause, exclusions, waiting periods, benefit reductions, who is covered, age limits, cancellation and renewals, choice of physician or hospital.

Better write to the Council on Medical Service, American Medical Association, 535 N. Dearborn Street, Chicago 10, for a supply of these for your reception room or for individual patients; no charge for a reasonable supply.

STATISTICS ON PRICES CAN BE MISLEADING

There has been a lot of loose talk about the increase in medical care prices. Obviously, such prices have increased. But comparisons which have been made with the increases in the prices of commodities have been fuzzy and misleading. In a recent issue of *The AMA News* there appeared an article which gives a clear picture of the situation. It offers an excellent answer for the physician to use in explaining rising medical costs to friends and patients. Said *The AMA News*:

"Articles asserting that medical care prices have outpaced the cost of living in the past 10



LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

years have overlooked or ignored the fact that medical care prices advanced relatively slowly from 1938 to 1948.

"An index based on the years 1947-49—a period falling almost in the center of an extended inflationary period—does not give a complete picture. It suggests that service prices rather than commodity prices lead the inflationary rise. This is contrary to prior economic experience.

"When the years 1938 to 1958 are included in the inflationary period, the index shows that commodity prices lead the rise.

"The Consumer Price Index increased faster than all sub-groups of the medical care price index except for hospital rates."

A chart which accompanied the article pointed out that for the years 1938-1958 the Consumer Price Index showed an increase of 104.8 per cent and that medical care including hospitalization increased 99.2 per cent; not including hospital costs, 70.4 per cent.

The chart also revealed that a breakdown of the components within the Medical Care Index showed the following increases: physicians' fees, 83.9 per cent; prescriptions and drugs, 44.0 per cent; hospital rates, 296.8 per cent.

WHAT ABOUT THIS QUESTION OF PRIVACY?

What about this question of a patient's right to privacy? When violated, does the patient have a cause of action against the physician?

"A patient has the same right of privacy that any other individual has. He has a right to have information relating to his condition kept secret and not made the subject of publicity.

"When a patient disrobes for an examination, operation or any other medical procedure, he does so for the professional benefit of the physician and he does not expect to be subjected to the examination of other persons, medical or non-medical, who are not necessary to the carrying out of the medical procedure. The admission of non-essential persons, without the specific consent of the patient, constitutes a violation of the patient's right of privacy."

The above is quoted from an article on "The Patient's Right of Privacy" published in *The New Physician*, publication of the Student AMA, and good advice it is. It was prepared by the AMA Law Division.

The same article adds the following notes of warning, also:

"The patient, when he submits to a medical procedure does not thereby consent to the taking

of his picture for future publication. The unauthorized taking of pictures of the patient, even though they have not been published, will give rise to a cause of action. One of the most frequent violations of a patient's right of privacy is the unauthorized use of his picture. It is immaterial that the patient's condition is made public because it is newsworthy and of interest to the public . . .

"Publicity may be given to the patient's condition, observers may be admitted and picture may be taken and published only if specifically consented to by the patient. To facilitate proof, if such should become necessary, the consent should be in writing. It should state specifically just what it is that the patient consents to with respect to observers, pictures, etc. If there are any restrictions or limitations on the consent they must be strictly observed."

BETTER SAVE YOUR OLD MALPRACTICE POLICIES!

Keep your expired malpractice insurance policies indefinitely! This is the good advice published in the medical-legal issue, July, 1959, of *The New Physician*, magazine of the Student AMA.

The article points out that a physician's current insurance does not protect him against an act of malpractice which occurred before the policy was issued. That act would be covered by an older policy. The policy in force at the time of the act must be relied upon. If a physician has changed companies, he should keep his former policies on file for reference until he is sure that the statute of limitations has begun to run.

LOCAL COLLECTION BUREAU YOUR BEST BET

The Medical-Dental-Hospital Bureaus of America recommend that physicians use local collection bureaus instead of the so-called "chain-store" bureaus. With this advice we wholeheartedly agree. The local bureau usually has established a reputation in the community. At least it can be personally checked without much trouble.

Even in dealing with a local collection service, the physician should be sure that it has a sense of the right way to deal with people. Not all patients whose accounts are placed with a bureau for collection are deadbeats. Some of them may be expected by the physician to continue with him—providing, of course, they haven't been subjected to shabby treatment by the bill collector.

The Better Business Bureau slogan about investigating before investing is a good one for the physician to follow in picking his collection agency.

For the treatment of infant colic SKOPYL quickly and effectively relieves and prevents abdominal pain and distention always identified with infant colic.

Easy Administration: Just one or two drops of SKOPYL under the tongue, 20 — 30 minutes before each feeding — or 3 drops for an acute attack of colic.

Fast Action: The rapid absorption of SKOPYL into the blood stream via the sublingual or oral route often gives immediate and dramatic relief of acute abdominal pain characteristic of infant colic.

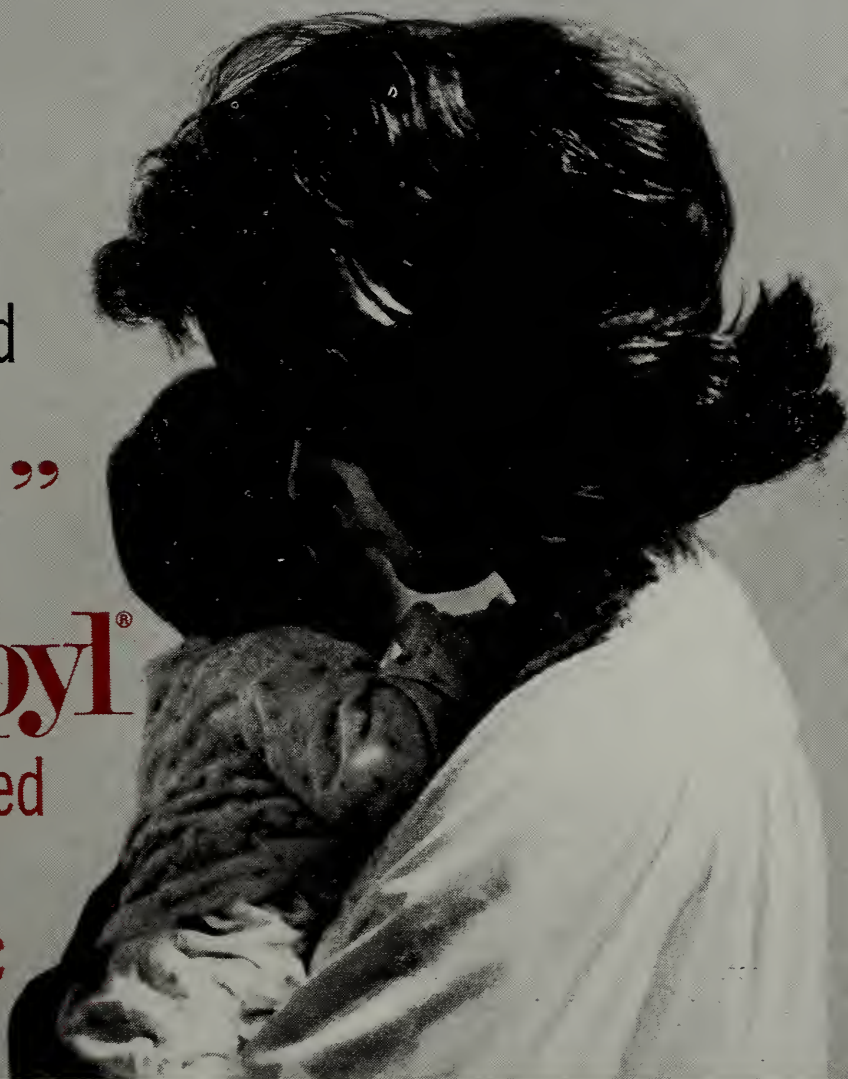
Effective: SKOPYL is more effective because of its selective peripheral action without influence on the central nervous system. Even when there is regurgitation and vomiting, SKOPYL is effective when administered orally or sublingually. During administration of SKOPYL, frequent, loose, and mucoid stools will become firm — often within 24 — 48 hours.

Action and Safety: The main effect of SKOPYL is peripheral. It has a particularly depressant effect on the tonus and motility of smooth musculature of the gastrointestinal tract. Because of SKOPYL's high degree of selective action and favorable therapeutic index, the recommended small volume dose can generally be given with a minimum incidence of side effects.

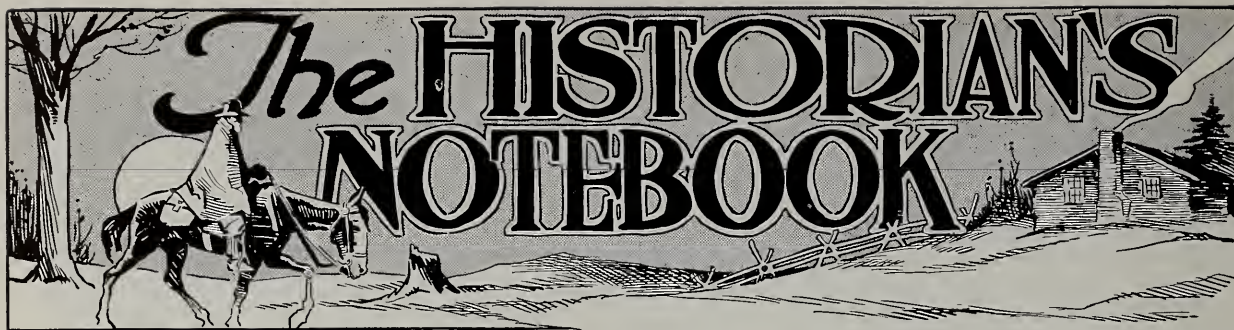
Indications: Colic (paroxysmal fussing, infantile dyspepsia, irritable crying), infantile vomiting, infantile diarrhea, pyloric spasm. **Precautions:** Fluid balance should be restored in dehydrated infants or those with oliguria before beginning treatment with SKOPYL. Available: 5 cc. dropper bottle.

One drop = 0.6 mg.; 40 drops = 1 cc.

“I
could
have
walked
all
night”
...but
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"Old Doc," First Auto Test Driver

JOHN A. MIRT

WHEN in 1901, the late Dr. Charles H. Mayo, noted surgeon of Rochester, Minn., in a letter to the editor of *The Journal of the American Medical Association* reviewed the relative merits of three types of a new-fangled "horseless carriage" he set off a chain reaction.

Dr. Mayo, who along with his brother, the late Dr. William J. Mayo, had founded the Mayo Clinic, was then the owner of a "steam buggy." He had operated gasoline-driven and electrically propelled machines as well. In his letter, he reported the advantages and disadvantages of each type, in answer to a previous request from a "Dr. H. S. J." in Lead, S. D.

The mechanical keenness of Dr. Mayo equalled his surgical skill for he concluded: "Steam is the most sure power, yet the rapid advancement of gasoline engines will undoubtedly make them the most convenient in another year."

Great Interest by Doctors

The letter elicited great interest in the new "contraption" among his medical colleagues. In the seven years to follow, the family doctor collectively was to become the test driver for the automobile industry, then in its infancy and subject to growing pains and the ills of improper nutrition. "Old Doc" was to report his "clinical" and "autopsy" findings in mechanical and scientific detail for the benefit of future motor car engineering and construction.

The Indianapolis Motor Speedway as a test of stamina for engines and accessories was not to come upon the scene until 1911. There were no proving grounds in those early days. No group was in a better position than the 100,000 physicians of the nation to give the automobile its needed, thorough workout, and to find its mechanical defects.

Competitive Reasons

To them, rapidity and certainty of transporta-

The Author

● Mr. Mirt is acting public relations director for the Illinois State Medical Society and his article was originally published in the *Illinois State Medical Journal*.

tion were material and practical considerations. The long time spent in travel was an economic waste. In some instances, the speed with which a physician reached his patient was a factor between life and death. So, he took up the new automobile not for pleasure but for professional—and competitive—reasons.

Manufacturers realized that there could be no greater testimonial for their products than to have the family doctor make his calls in city and country by auto. Promotion was directed at the medical profession. Physicians gradually switched from horses.

"Doc" guided his automobile over city and country, on good roads and bad, through mud, snow, sand and clay, up hill and down, day and night, winter and summer under every weather and road condition imaginable. He went out when other car owners dared not.

Did Own Repairing

When the mechanical "bugs" of his machine showed up—and this happened much too frequently—he had no one to turn to for help. Repair shops were few and far between. Moreover, mechanics were of little help because of lack of standardization of parts and designs. Each model of car required a particular knowledge of its workings. So, he had to "get out and get under." With the aid of a few choice, non-medical words, he did the repairing himself.

It became evident that medical and mechanical

emergencies were Siamese twins. In order to deal with both, the physician learned the mechanics of an automobile the hard way. He pored over technical books dealing with the principles of gasoline and steam engines, electric motors, fuels, storage batteries and other accessories. He tinkered with a car in a stall in an old stable. In time, he came to know the anatomy of his automobile as well as that of his patients.

Reports in AMA Journal

The Journal carried spasmodic and individual reports from physicians on their experiences with the new form of transportation. By 1906, the automobile was recognized as an important potential factor in better medical care. Yet, manufacturers were not far along the way to solving their mechanical problems.

On March 24 of that year, *The Journal* editorially took cognizance of the uncertainty which existed. It had compiled a large number of experience reports, but wanted more.

"To no one class of people is the automobile of more practical importance as a business proposition than to physicians," the medical publication said. "Whether in the city or country, the physician needs a means of quickly, safely and surely reaching his patients—and of getting home again."

Asked for Reports

It asked for reports on both sides of the subject—"experiences and difficulties connected with the machine as compared with the horse, the type of car most practical, technical points connected with gears, transmissions, cylinders, fuel, cooling apparatus, tires, etc."

On April 21, 1906, 36 pages were devoted to the driving experiences and suggestions of 68 physicians. "Clinical" and "autopsy" findings were reported in great detail. "Treatments" were prescribed. Advice was given on how to avoid "symptoms" of a disorder. "Systemic weaknesses" were revealed, pointing the way to future engineering designing. The pros and cons of every type of power, transmission, electrical system, cooling method, wheel and tire were presented. Each accessory had its proponents, who gave sound mechanical reasons for their opinions. The argument was heated.

Offers Specifications

Typical of the detail in specifications was the recommendation of Dr. C. E. Rogers, Montevideo, Minn. Based on ownership of three cars and travel twice the distance around the world, he said: "The engine should be multiple cylinders; gasoline is best and cheapest fuel; sliding gear transmission;

drive of the shaft pattern; cooling system, water; half elliptical springs; double tube tires; storage battery for spark and ignition; acetylene lamps."

Solid tires worked best on mud roads, according to Dr. Eugene F. Talbott, Grinnell, Iowa. The pneumatic tire was "too wide to go into the rut made by wagon wheels."

He had many supporters because pneumatic tires in those days were in disfavor despite their easier riding qualities. Flat tires were too common occurrences to suit physicians on a hurry call.

Only on one point was there agreement. The physician had to be an auto mechanic as well as a medical man.

Should Be Trained, He Says

A purchase should not be made unless the physician also undergoes training in gas engineering, Dr. C. P. Thomas, Spokane, wrote. He added: "He should know the mechanics of his car as well as he knows his surgical instruments." He advised his colleagues to "get on the band wagon" because the automobile was here to stay.

"Study and understand your car as you do the human body," Dr. Rolandus G. Walker, Denver, recommended. "Learn to diagnose your trouble when it arises. Understand the physiology of your engine. Apply the treatment as when you prescribe drugs in your daily practice."

When Dr. F. J. Bomberger, Mapleton, Minn., had trouble on the road and was asked: "What's bothering you, Doc?" his reply was: "My deplorable ignorance." Then he took up a study of gasoline engines and his troubles ceased.

From Dr. William Thompson, Chicago, came the sage advice concerning autos: "Study its anatomy and physiology, and all the pathology that you can acquire."

Should Know Car's Pulse

Dr. Harry S. Kiskadden, Detroit, urged physicians to be able to tell the "pulse and respiration" of their cars. The automobile of Dr. W. P. Hartford, Cassville, Wis., was subject to "attacks of indigestion" and sometimes was suspected of "malingering."

Although the "three-wheeler" purchased in 1901 by Dr. H. C. Martin, Springfield, Mass., "coughed and coughed" for six years, it was good for 50,000 miles. The secret: He spent 30 to 45 minutes each morning checking "the whole wagon."

Irked by jibes when a breakdown occurred, Dr. Charles Moir, Louisville, donned overalls and "made a thorough dissection of his machine." He reported: "Result: No more street scenes, as I can

(Continued on Page 1504)

avoid the risk of insoluble, irritating aspirin particles

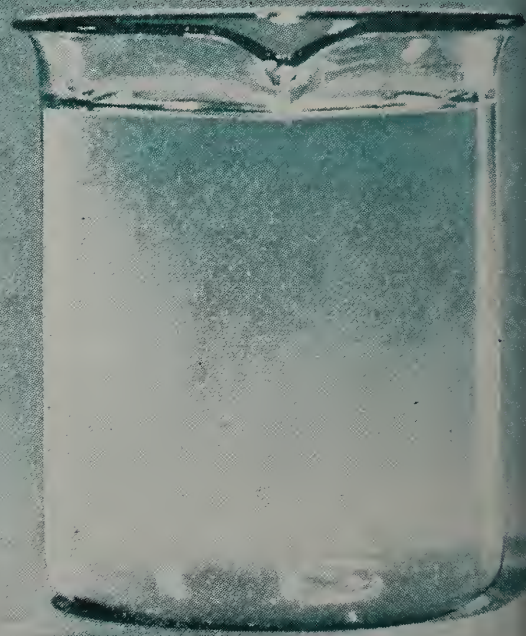
Chief among the drawbacks to aspirin usage is gastric intolerance. This ranges from mild upset and "heartburn" to severe hemorrhagic gastritis.¹⁻¹⁰ Studies performed in conjunction with gastrectomy^{4,5} and gastroscopy² have shown insoluble aspirin particles firmly adherent to

the gastric mucosa and imbedded between rugae. Reactions varying from mild hyperemia to erosive gastritis have been reported to occur in the areas immediately surrounding these adherent particles.^{2,4,5} This is reported to be particularly true in patients with peptic ulcer.⁴

CALURIN is the freely soluble, stable calcium aspirin complex. Its high solubility forestalls gastric irritation or damage



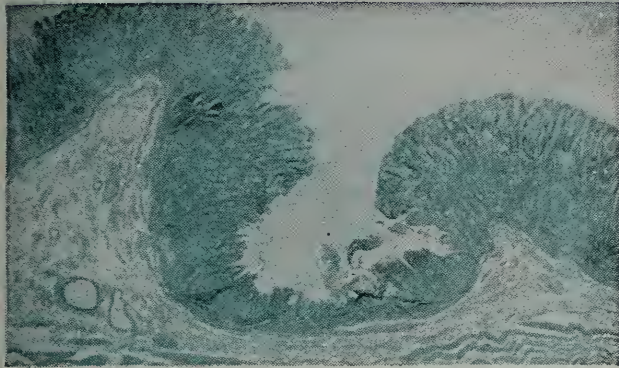
Regular aspirin crystals 24 hours after being mixed into water.



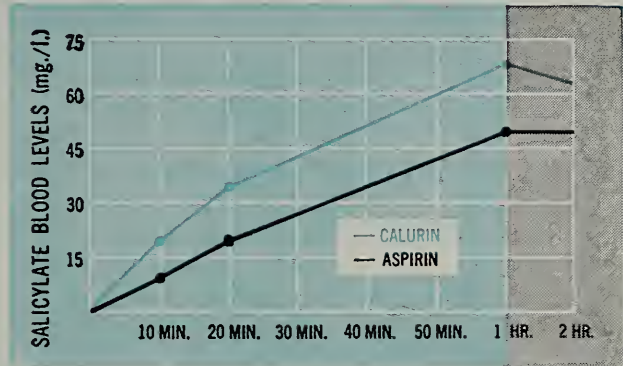
Calurin crystals in solution one minute after being mixed into water.

CALURIN*

STABLE SOLUBLE CALCIUM-ACETYLSALICYLATE-CARBAMIDE



Particle-induced ulceration — section through lesion found in gastrectomy specimen. An aspirin particle was found firmly imbedded in this undermined erosion. Such lesions may be associated with the relative insolubility of aspirin, which remains in particulate form after dispersion in gastric contents.



Calurin, being freely soluble, is promptly available for absorption into the systemic circulation. Salicylate blood levels in 12 subjects receiving both Calurin and plain aspirin were found to rise more than twice as high within ten minutes following Calurin. Also, these levels persisted higher for at least two hours.¹¹

CALURIN is the aspirin of choice, especially when high-dosage, long-term therapy is indicated:

- 1 High solubility forestalls gastric irritation or damage. This advantage is of special importance in arthritis and other conditions requiring high-dosage, long-term therapy.
- 2 Produces high salicylate blood levels rapidly for prompt analgesic, anti-pyretic, anti-arthritis effect.
- 3 Sodium-free — for safer long-term therapy.
- 4 Flavored: can be chewed or dissolved in the mouth without water if desired — an advantage for patients requiring aspirin administration during the night and for pediatric patients.

Dosage: Each tablet of Calurin is equivalent to 300 mg. (5 gr.) of acetylsalicylic acid. For relief of pain and fever in adult patients, the usual dose of Calurin is 1 to 3 tablets every 4 hours, as needed; in arthritic states, 2 or 3 tablets 3 or 4 times daily; in rheumatic

fever, 3 to 5 tablets 4 or 5 times daily. For children over 6 years, the usual dose is 1 tablet every 4 hours; for children 3 to 6 years, ½ tablet every 4 hours, as required. Not recommended for children under 3.

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*TRADEMARK

get started before the crowd gets around. As for a vocabulary of interjulatory speech, I do not need it rewritten, and I am now going to teach a Sunday school."

Dr. F. M. Crain, Redfield, S. D., was prophetic when he wrote: "One of the beneficial results of the use of the automobile will be its effect on the good roads movement."

Comparison of Costs

In contributing to the symposium on comparative cost of automobile and horse, Dr. Charles P. Sylvester, Dorchester, Mass., gave a report which would do credit to a certified public accountant. Expenses listed included a \$5.25 item for "loss of eyeglass while raising a 30-mile breeze in the woods" and 10 cents carfare when his automobile had to be left behind after a breakdown. Charges against horse upkeep included eight cents for sugar and 50 cents for gin—not explained. The automobile came out \$110.45 cheaper over seven months.

He was analytical in other respects. He kept tab of his pulse beats and found the tension of long drives increased his rate by six beats per minute. "The public's probably went higher," he added.

Took Horse and Buggy Along

Dr. C. B. Miller, Helena, Mont., was a skeptic on his first trip to see a patient six miles out in the country. He had his horse and buggy follow him. The caution paid off. On the way back, he experienced carburetor trouble. Eventually, he mastered the intricacies of the vehicle and became a booster.

"The traumatism of the conjunctiva in motoring is very severe and one should always wear goggles," Dr. Joseph A. Robertson, New York, advised. He discussed in mechanical detail the relative merits of various types of accessories.

But not all reports were favorable to the new industry. A sad experience was related by Dr. Sterling Gibson, Thomson, Ga. He thought by buying an automobile he could dispose of one of his two horses. But he reported: "I found I would have to get a third horse."

Experience with an 8-h.p., one cylinder, water-cooled gasoline runabout in country practice for two seasons caused Dr. F. A. Swezey, Wakonda, S. D., to report: "I will never buy another."

Good Plug for Companies

Subsequent letters to the editor showed that physicians all over the country appreciated this special feature. One point made was that the experiences would awaken manufacturers to the problems of motoring, especially in cases where cer-

tainty of performance under adverse conditions was of paramount importance.

From Dr. J. D. Southard, Fort Smith, Ark., came the prediction: "This edition of *The Journal* will increase the sale of automobiles more than anything that has ever happened."

Producers apparently were of the same mind because several were represented at a commercial exhibit alongside surgical supplies, pharmaceuticals and other doctors' needs at the annual meeting of the American Medical Association in Boston in June, 1906. They experienced an unusual professional interest in "motor cars adapted to the physicians' use."

More Reports Asked

By the fall of 1907, physicians from all parts of the country were asking for more information. *The Journal* called for reports on one, two and four-cylinder machines both as to efficiency and cost of operations.

It wanted to know the comparative value of large and small cars; the relative usefulness of the automobile on various kinds of roads—loam, clay, sand, etc., hilly and level; the methods used to prevent skidding; the relative merits of air-cooled and water-cooled cars; the anti-freezing material used; the preference, whether for electric, steam or gasoline automobiles, and why.

"Experiences, not theories are wanted," *The Journal* emphasized.

On March 7, 1908, in a number which carried articles on "Subphrenic Abscesses as a Condition of Appendicitis," and "Exophthalmic Goiter," 27 pages were devoted to "The Physician's Automobile." More than 100 reports were contributed by physicians.

Varied Illustrations

Illustrations showed physicians' cars sloshing through water holes on country roads, pushing through snow drifts or bumping over rock-littered roads; cars with tops up, tops rolled back, no tops; drivers in dusters, caps and goggles; machines with high wheels or low wheels; cars with pneumatic tires or solid tires.

Usually, the physician was pictured at the wheel. One illustration showed him in the back seat while his wife and daughter sat up front.

Operating expenses were reported in great detail. Physicians gave the relative costs of keeping a "hay burner" and a "gasoline burner." Which mode of transportation the figures favored depended largely on repair expenses.

Some physicians found it cheaper to operate an automobile, but few took into consideration the matter of depreciation. Others said horse and buggy were less expensive, but many added that

the time saved more than offset the added cost of a car.

Trend Established

By then, the preference trend had been established. Trials under all conditions had brought out the better advantages of gasoline engines, pneumatic tires, multi-cylinder motors, drive shaft transmission, sliding clutch, water cooling systems and low wheels. These were reported in mechanical detail and these were to become the specifications for the "physician's car."

The consensus was that the physician should own an automobile, but more than half of the physicians still emphasized that knowledge of mechanics was a requisite to satisfactory operation.

So widespread was the demand of physicians for mechanical knowledge that among books advertised in *The Journal* was J. E. Homan's *Self-Propelled Vehicles*. Described as a "thorough course in the science of automobiles," it contained more than 400 illustrations and diagrams.

"Ace In the Hole"

Nevertheless, the horse and buggy remained "an ace in the hole" for many physicians. Dr. E. T. Fields, Ensley, Ala., kept a team in reserve. In Lubbock, Tex., Dr. M. C. Overton depended on hired horses for use in muddy weather.

Memphis in those days had many unpaved streets. Dr. Max Henning of that city advised his confreres not to buy an automobile unless a horse and buggy were kept for use on bad streets.

Summarizing the opinions of physicians, *The Journal* said: "The automobile, while far from perfect, has reached that stage where it is a practical and economical conveyance under certain conditions. To the physician who has some mechanical genius, it is not only a welcome substitute for the horse, but it is a valuable means of recreation and diversion."

Industry Complies

It made recommendations which the automobile industry adopted: Standardization of parts to cut production and maintenance cost; a \$500 car, which Henry Ford eventually produced; reliability of performance; simplicity of construction to make parts easy to reach.

The editor decried the craze for speed and called for a 20-mile-per-hour-limit. He urged physical qualifications for drivers, pointing out that "if an automobilist is out of health, nervously weak, defective in sight and hearing, or under the influence of drugs or stimulants, he is not a safe man to run an automobile."

Used For Foreign Bodies

Physicians occasionally used their automobiles

for other than transportation purposes. Dr. A. R. Baker, Cleveland, connected the battery in his electric car to an electro-magnet in his office. The power delivered excelled street current for magnetic removal of steel and iron from the interior of the eye in more than 30 cases, he informed his colleagues.

In Rome, N. Y., Dr. W. B. Reid found that the lighting in country houses frequently was insufficient for emergency surgery. He backed his automobile to a window, passed the acetylene lamp into the house and connected it with the gas tank on his automobile by means of a rubber tubing.

"The light is as good as in any well-appointed operating room," he reported.

Dr. J. H. Guinn, Arkansas City, Ark., ran wires from his garage to his office, connecting the battery in his electric automobile to electro-therapeutic apparatus. He eliminated "the annoyance and expense in keeping up a galvanic apparatus," he wrote.

Cars Displayed

At the American Medical Association's annual meeting in Chicago in June, 1908, five automobile makers displayed their products. Buick and Cadillac had special "physicians' cars." Bendix Company, Chicago, had a four-cylinder, high-wheel model. Doctors were invited to tour the Bendix plant to see cars in construction.

Holsman Automobile Company and J. V. Linsley & Co., Chicago, had displays.

For the physician who still was not sold on the automobile, or who wanted a backstop, Heinzelman Brothers Carriage Co., Belleville, Ill., exhibited two of its popular style buggies.

Special Edition

On March 6, 1909, a third automobile section was published. It comprised 34 pages. Automotive engineers contributed articles as well as physicians. There were symposiums on wheels—low and high; on tires—solid and pneumatic; on motors and transmissions; on lubrication.

Dr. J. E. Alleben, Rockford, Ill., likened the advance in the automobile industry to that in surgery—"after many years of patient labor and experiment."

From then on, the automobile industry grew fast. In 1911, the Indianapolis Motor Speedway staged its first 500-mile race, to put the automobile to a grueling test. This merely added speed to the earlier trials.

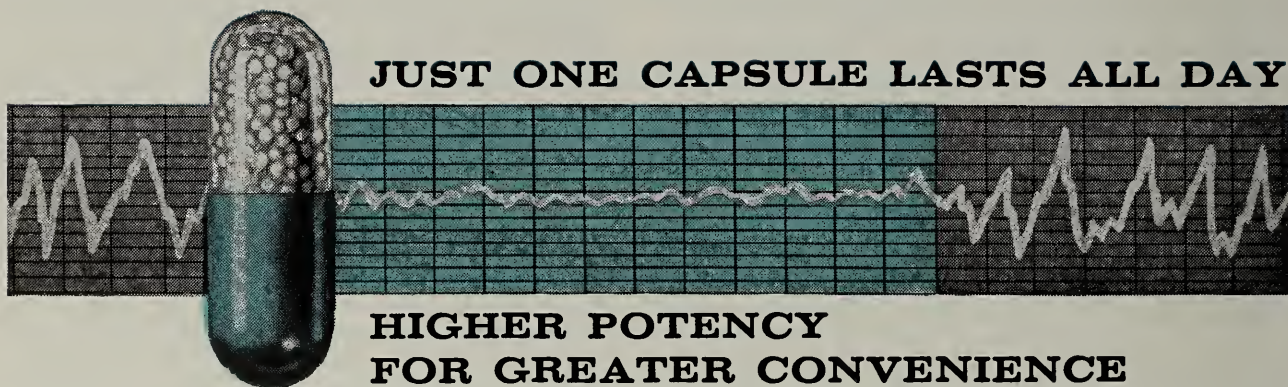
But the physicians of the country had served as the first test drivers under actual road conditions.

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- does not impair mental efficiency, motor control, or normal behavior

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400 mg. Miltown (meprobamate)
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Both potencies in bottles of 30.

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PERRY R. AYRES, M. D., *Editor*

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Asst. Managing Editor

Clinical Use of the Insulins in the Treatment Of Diabetes Mellitus

JOSEPH I. GOODMAN, M. D.

IN DISCUSSING the indications for the use of insulin it should be mentioned at the outset that too many people use insulin who do not need it. The chief offender is the obese individual whose diabetes can be regulated without insulin. If anything, his condition is rendered worse by the use of insulin and his obesity increases. In contrast to the adults of this type all diabetic children require insulin. Moreover, through the years of growth and development the insulin needs will, in the average patient, increase gradually.

In contrast to some drugs, such as antibiotics, in the use of which dosage and form of preparation are of less importance, the dosage and *type* of insulin are paramount. This is explainable in part by the fact that no two diabetics are exactly alike. In fact, they vary so greatly from one patient to another that no one preparation of insulin can be completely suitable for *all* patients. The ideal type of insulin, which has been sought for many years, would be a preparation which, with a single daily injection, releases insulin from the site of injection at such a rate as to correspond with the patient's need at the moment. The long-acting and intermediate insulins available at the present time fall far short of this goal. We are forced to conclude therefore that the ideal insulin to suit all diabetics has not yet been discovered.

Most physicians are familiar with the several

The Author

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modifications of insulin which have been made available during the past 35 years. The highly purified amorphous preparation was followed by crystalline zinc insulin and, later, by globin and protamine zinc insulin. With three insulins available, the treatment of *diabetes mellitus* seemed simple enough until 1953. In that year, with the introduction of NPH ("isophane") insulin it seemed as if the story had been complete. Then, early in 1954, came the insulin zinc suspensions, three of them, viz., ultra-lente, semi-lente and lente insulin. Consequently, there are seven preparations (though only six varieties) and treatment is no longer simple. Each preparation is potent and each is effective if properly used. The physician's problem is when and how to use these insulins to the best advantage.

The unwise, indiscriminate use of insulin has many causes. The effect of any insulin depends on a number of factors, the most important of which are the following: (1) the characteristics of the patient, (2) the characteristics of the insulin, (3) the dose of insulin, (4) the distribution of the

This is the third in a series of four articles prepared by the author, dealing with the insulins and the oral hypoglycemic agents, the first two papers having been published in *The Ohio State Medical Journal*, November 1958, and June 1959, respectively.

Submitted March 20, 1959.

diet, (5) exercise, and (6) the presence of acute complications such as infection.

The influence of the patient's characteristics is illustrated most strikingly by those diabetics who are variously known as difficult, unstable, brittle or labile. The obese diabetic, on the other hand, may do worse on insulin than on diet alone since the objective of weight reduction depends on a number of factors.

The initial choice of insulin is based on the knowledge of the action of the various insulins the characteristics of which are known and within certain limits predictable. The properties of each insulin (promptness, intensity, peak period and

the period of greatest insulin action is the most effective measure in the prevention of insulin reactions. In effect, the distribution of food is geared to the maximum time of action of the insulin.

Data on the Individual Types of Insulin

For clinical purposes the insulins may be divided into three groups: 1. Short-acting insulins—(a) regular insulin, (b) semi-lente insulin; 2. Intermediate-acting insulins—(a) globin insulin, (b) NPH insulin; 3. Long-acting insulins—(a) protamine zinc insulin, (b) ultra-lente insulin. Lente insulin, has the properties of both of its compon-

TABLE 1.—*Properties of the Various Insulins*

Type of Insulin	Onset of Action	Intensity of Action	Peak Period of Action	Duration of Action
Regular insulin	Less than 1 hour	++++	3 to 4 hours	8 hours
Protamine zinc insulin	6 to 8 hours	+	16 to 24 hours	24 hours +
Globin insulin	2 to 4 hours	++	8 to 10 hours	20 hours
Isophane (N.P.H.) insulin	2 to 4 hours	++	8 to 12 hours	24 hours
Amorphous insulin zinc suspension (semilente—I.Z.S. (A))	1 to 2 hours	+++	4 to 8 hours	12 to 14 hours
Crystalline insulin zinc suspension (ultralente—I.Z.S. (C))	6 to 8 hours	+	16 to 24 hours	24 hours +
Insulin zinc suspension (lente)	Early, owing to I.Z.S. (A)	++	Two peaks: early, due to I.Z.S. (A); late, due to I.Z.S. (C)	24 hours +, due to I.Z.S. (C)

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duration) are shown in table 1. The size of the dose has its effect on insulin action. Thus, the larger the dose the longer the duration of action and the later the period of maximum action. The general pattern of action is not altered thereby.

Because the effect of insulin is cumulative to a certain degree no insulin acts at maximal efficiency in the first 7 to 14 days that it is employed. Hence, any particular dose of insulin should be continued for at least a few days or longer rather than resorting too soon either to another insulin, to "supplemental" doses of a second insulin, or even to an increase in dosage of the original type. In other words, in estimating insulin dosage, it is safer to lean toward a lower dosage than to an overdosage. The patient will rarely go into hyperglycemic coma with an insufficient insulin dosage, but the hazard of insulin reaction with overdosage is very great and occurs far too commonly.

One comment concerning insulin should be made at this point. Soon after patients with previously untreated diabetes have been brought under control, one usually discovers that the daily dose of insulin declines over the ensuing weeks or months.

The distribution of the diet during the 24 hours is very important. A meal designed to counteract

ents; its early action is due to the amorphous fraction and its sustained long action is due to the crystalline fraction.

1. The Short-acting Insulins

(a) *Regular or Crystalline Insulin.* Regular insulin is also known as unmodified, soluble, original or just plain insulin. The most commonly used term is regular insulin. It is a clear, aqueous solution of pH 3.0 to 3.5, and contains no buffer. The amorphous and crystalline forms are identical in action (table 1). Regular insulin is a quick, vigorous-acting, short duration insulin which exerts an effect on the blood sugar within 20 to 30 minutes after injection. Its maximum effect occurs within two to four hours and the total duration of action is six to eight hours. In the author's opinion this type of insulin, administered in one or two small doses, is ideal at the start of treatment of a new diabetic (see table 2). There are still a few remaining members of the "old guard" who started on regular insulin in the early days, were well controlled by it and prefer not to make a change as new insulins came along. It is recommended that they be left alone.

(b) *Semi-lente Insulin.* Semi-lente insulin is an amorphous insulin zinc suspension which is in-

TABLE 2.

JOSEPH I. GOODMAN, M. D.

2460 Fairmount Boulevard

Fractional-Urinalysis

NAME S. D. — Age 10
IDEAL WEIGHT 91 at Age 10DIET Cal. 2200
9/ 8/58 — 1800
11/17/58 — 1500

Date 1958	Weight	Breakfast-Lunch			Lunch-Dinner			Dinner-Edtime			Bedtime-Breakfast			Total 24 hrs. Grams
		Insulin	% Volume	Grams	Insulin	% Volume	Grams	Insulin	% Volume	Grams	Insulin	% Volume	Grams	
7-7	68½		3.0/1900	57.00										57.00
7-10	69½	10R	4.0/240	9.6		4.0/600	24.0		5.0/480	24.0		5.0/1260	63.0	120.6
7-14	70¾	10R	12/510	60.6		0+/600	0+	5G	12.0/780	93.6				154.6+
7-17	72¼	15R	10.0/240	24.0		9.5/840	75.6	5R+5G	10.0/480	48.0		9.5/690	62.1	209.7
7-21		15R+5G	9.0/180	16.2		8.0/780	62.4	5R+5G	10.0/390	39.0		9.0/1200	108	225.6
7-24	72¼	15R+10G	9.0/300	27.0		9.0/510	45.9	5R+10G	8.0/210	16.8		6.0/840	50.4	140.1
7-28	73½	15R+10G	5.5/180	9.9		3.5/300	10.5	5R+15G	9.0/150	13.5		3.0/840	13.4	47.3
7-31	74½		4.5/60	2.7		4.0/300	12.0		0+/330	0+		1.5/540	8.1	22.8
8-14	81		0/0	0		0+/480	0+		0/150	0		0+/540	0+	0+
8-28	86		0/30	0		0/540	0		0/150	0		0/780	0	0
9-8	86¾		0/180	0		0/540	0		0/150	0		0/660	0	0
10-20	88¾	12R+10G	0+/150	0+		2.5/150	3.75	4R+12G	2.0/270	5.4		0/0	0	9.15
11-17	92½		2.0/180	3.6		5.0/210	10.5		6.0/570	34.2		5.0/690	34.5	82.8
11-24	93	12R+10G	0/150	0		2.0/300	6.0	6R+12G	0+/195	0+		0/390	0	6.0

Legend: R-Regular Insulin; G-Globin Insulin; PZI-Protamine Zinc Insulin

intermediate in action between regular and globin insulin, and has a duration of effect of about 12 to 16 hours in large doses. It is not as prompt in onset as regular insulin (about half an hour later) or as vigorous in action, but its effect lasts longer, though not as long as that of globin insulin.

2. Intermediate Insulins

(a) *Globin Insulin*. Globin insulin is a solution of insulin combined with globin and zinc. Its maximum effect lies somewhere between that of regular insulin and protamine zinc insulin (PZI). This insulin acts fairly quickly, lowers sugar within two hours, reaches its maximum action six to eight hours after administration, and in large doses lasts from 15 to 18 hours. Patients are encountered where glycosuria appears postprandially without any nocturnal glycosuria whatever and they do very well on globin insulin which acts well during the 12 hours or so associated with meals. There is an infrequently encountered group of diabetics who are very well regulated by two small doses of globin insulin taken 12 hours apart. Many clinicians (including the author) cannot agree that the action curve of globin insulin is an exact replica of NPH.

The author has found a valuable niche for globin insulin in severe diabetics used as a mixture with regular insulin either in the morning dose or, in most of the difficult and younger diabetics, in a second injection given before dinner (table 2). Thus, in the morning injection, the regular insulin acts principally between breakfast and lunch, the globin between lunch and dinner. Similarly, in the evening injection, the regular in-

sulin works chiefly in the early evening and the globin throughout the night.

(b) *NPH Insulin*. NPH (neutral protamine Hagedorn) insulin is also known as isophane insulin. It is a suspension of specially prepared zinc insulin crystals buffered to pH 7.2 with disodium hydrogen phosphate. It contains much less protamine than protamine zinc insulin and all of it is combined with the insulin. NPH insulin is similar in action to globin insulin, its onset occurring about two hours after injection, the maximum effect six to eight hours later and a duration of action of 12 to 16 hours. When given in large doses in the morning its effect lasts until the next morning.

As in the case of globin, regular or crystalline insulin can be added directly to NPH insulin, in the same syringe, without interfering seriously with the rapid action of the regular insulin. Such an addition will exert its own action since there is not enough free protamine in the NPH insulin to combine to any extent with the regular insulin so added. NPH is not intended to replace all other types of insulin. In a significant percentage of patients, the effect of NPH insulin diminishes greatly before 24 hours have elapsed as can be seen by fasting hyperglycemia and nocturnal glycosuria despite minimal glycosuria throughout the day.

(c) *Lente Insulin*. Lente is a ready-made physical mixture of seven parts of ultra-lente and three parts of semi-lente. This product closely resembles globin and NPH insulin in action, and it is in fact completely interchangeable with them. The

amorphous component provides the prompt early action and the crystalline component the prolonged effect.

3. Long-acting Insulins

(a) *Protamine zinc Insulin*. For all practical purposes protamine zinc insulin has been replaced by other more suitable preparations.

(b) *Ultra-lente Insulin*. Crystalline insulin zinc suspension is also known as ultra-lente insulin. It is a crystalline product produced similarly but under a different pH than semi-lente insulin. It is similar in action to protamine zinc insulin; it is a slow starter, but steady and prolonged in effect. It acts for at least 28 to 36 hours.

The Lente Group

The insulin zinc suspensions were discovered by Hallas-Møllar and associates while studying the relation between zinc and insulin. They found, by substituting a sodium acetate buffer for the customary phosphate buffer, that insulin in the presence of small amounts of zinc became less soluble and more prolonged in action. By adjusting the pH amorphous and crystalline compounds were obtained. The duration of action varied with the physical state of the insulin zinc compound, the crystalline form acting much longer than the amorphous one.

Basically, there are only two insulin zinc suspensions, the amorphous suspension and the crystalline suspensions. The insulin zinc suspensions are identical chemically but differ in physical form, being either amorphous or crystalline. They are buffered to pH 7.2 with sodium acetate, and in mixture each retains its own form and action. As a result of the differences in these three lente preparations, advantage may be taken of their particular characteristics. It should be stressed that semi-lente and ultra-lente are the same product and therefore can be mixed in any proportion at will.

After much clinical trial Hallas-Møllar found that a mixture of three parts of the amorphous suspension and seven parts of the crystalline suspension worked well on a majority of diabetics. The success of this 3:7 mixture led to its being marketed along with the separate amorphous and crystalline suspensions.

Nomenclature. The insulin zinc suspensions are known by various names which is confusing. Hallas-Møllar named them insulin semi-lente, insulin ultra-lente and insulin lente, semi-lente being the amorphous suspension, ultra-lente the crystalline suspension, and lente the ready-made mixture of semi-lente and ultra-lente. He and others have used the term "the lente insulins" as a group name

for all the insulin zinc suspensions. The similarity between the group name and the individual name for the ready-made mixture "lente insulin" is surely confusing.

Insulin zinc suspension (amorphous) and insulin zinc suspension (crystalline) are precisely descriptive of the nature of these insulins. Insulin zinc suspension as a name is less satisfactory. It is clear enough that the preparation is an insulin zinc suspension but its true nature is not stated with the exactness of the other two suspensions. However, the alternative names, semi-lente insulin, ultra-lente insulin and lente insulin are even less satisfactory. These names tell nothing of the nature of the insulins. Literally they mean half slow, slow, and extra slow insulin, which is not very illuminating.

Indications for Use of Various Insulins

Confusing as it is to have so many insulins, the physician has to accept this situation and overcome the handicaps by wise choice and intelligent use. The difficult diabetics illustrate in striking fashion the influence of the individuality of the patient on the response to insulin. The variability of response is a fascinating field for study for we know little or nothing about the factors involved.

A new insulin is a temptation to both physician and patient. The physician may be influenced by favorable reports to change his diabetics to the new insulin. The patient, on the other hand, may believe it to contain some magic property not in his present insulin. In fact, some diabetics are anxious to try anything new even though there is no compelling reason for a change. The physician is obligated to inform the patient that it is impossible to predict the response to any new preparation insulin or otherwise.

A change in insulin should not be made lightly. It is a golden rule never to tamper with a well regulated diabetic who has nothing to gain and may actually lose by a change. The actual change-over of a patient to another insulin should be carefully supervised by the physician since possible untoward effects of the transfer cannot be foretold.

A large percentage of patients require regular insulin plus an intermediate insulin, taken 30 to 60 minutes before breakfast, in order to overcome an excessive forenoon glycosuria. This is achieved by adding regular insulin to globin or NPH insulin. It has been our experience that patients who have been most difficult to regulate, are those who profit most from institution of the mixture. Most patients appear to maintain good diabetic control during hospitalization. The true test of

any insulin preparation, however, comes many weeks after discharge when it is not unusual to find that the control of the diabetes has once again deteriorated.

With all severe types of diabetic patients, and in most children, a single injection of insulin—globin, NPH or lente, with or without regular insulin, does not suffice for adequate control. This occurs for various reasons chiefly however because the effect of the intermediate insulins, even, in large doses, does not last for a full 24 hours. This necessitates giving a second dose of insulin before dinner (see table 2). Appropriate mixtures of regular and intermediate insulins (the author prefers globin), has greatly increased the facility with which accurate control of diabetes can be achieved in severe cases. It is well to bear in mind the important fact that every case is an individual problem and requires constant readjustment of insulin dosage.

Food Distribution

Prevention of insulin reactions can and must be achieved in every patient. This necessitates that the timing of the various insulins be kept uppermost in one's mind (table 1) in planning the daily food intake. All the long-acting insulins have a slower onset of action than regular insulin and, when given in the morning, as they usually are, a relatively small breakfast is desirable. The food which is deleted from breakfast is then taken later in the day at the time of maximum action of the insulin.

Globin insulin acts strongly during the middle and late afternoon and reactions with this insulin generally occur then. NPH insulin also acts strongly in the afternoon, a mid-afternoon feeding will effectively prevent reactions with these insulins. Lente insulin, being a mixture of an early-acting insulin and a long-acting insulin, has two periods of maximum activity, one in the afternoon and occasionally before lunch, and the other during the night; afternoon food and bedtime feeding are therefore advisable. When long-acting insulins are being given, a liberal allowance of protein or fat foods must be eaten at bedtime.

Glucose is formed slowly from protein and so is available in a steady flow over many hours to counteract the insulin. It should be emphasized here that the existence of heart disease does not contraindicate the use of insulin although it is true that hypoglycemia must be strictly avoided.

An occasional patient may have a local reaction to any type of insulin. In my own practice allergic reactions to the commercially produced insulins are uncommon. Most insulins are extracts of beef

and pork. When allergic reactions occur, "special insulin" should be prescribed.

Method of Insulin Administration Used by Author^{1,3}

Following a sufficient trial period on diet alone, insulin therapy is begun in patients in whom the 24-hour glucose excretion exceeds 10 grams, with small doses of regular insulin—5 to 10 units administered 30 to 45 minutes before breakfast and, if needed, before the evening meal. Certain diabetics can be controlled by a single dose of regular insulin before breakfast. If, after two or three days, the glycosuria is unaffected the dosage is increased, 3 to 5 units per dose, until the total 24-hour urinary glucose excretion drops below 10 grams.

Inasmuch as the maximum effect of any increased insulin dose is not attained for several days, or even weeks, a further increase in dosage should be postponed until it is certain that the maximum effect has been achieved; in other words, until there is no further decrease in the 24-hour glycosuria. Of course, when the urinary sugar content is diminishing progressively on a given insulin dose, the same dosage is maintained until the total 24-hour glycosuria drops below 10 Gm. This principle is especially important in newly discovered diabetic patients whose carbohydrate tolerance usually improves so rapidly that rapid increments of insulin would certainly invoke hyperglycemia. By waiting for the full effect of a given insulin dose to become established, as determined by the quantitative determination of glycosuria, insulin doses can be increased accurately until the 24-hour urine contains less than 10 grams of glucose.

When, on a morning dose of regular insulin, either the total 24-hour excretion exceeds 10 Gm. or there is excessive glycosuria in fractional specimens 3 and 4, a second dose of regular insulin is prescribed before the evening meal. It is frequently possible to transfer a patient in whom the total daily dosage of insulin does not exceed 20 to 30 units from two doses of regular to a single dose of intermediate-acting insulin. Although globin insulin with zinc is the author's preference, patients in this category usually do equally well on other intermediate insulins. Patients who present significant nocturnal glycosuria respond very well either to a single dose of globin insulin with zinc, administered before the evening meal or in the same syringe with regular insulin.

It should be emphasized that a relatively long period of time, an average of 18 months per patient in severe cases, is necessary to stabilize the insulin dosage. Patience is a necessary requisite

for success since two cases of diabetes are rarely alike. Not only does the insulin requirement differ from one diabetic to another but the dose of insulin in every patient varies from time to time. The question of insulin therapy therefore resolves itself into one of trial and error. Still, provided a given patient lives under conditions of uniform health and activity, an insulin dose may be ultimately found which proves to be more or less permanent for him.

The following simple guides apply to every patient taking insulin:

1. Do not alter your insulin dose, let the doctor do it.
2. Do not increase insulin doses because of dietary indiscretions since you have no basis to know how much to increase it.
3. Do not fail to take extra food prior to unusual exercise.

Technique of Insulin Administration

Insulins are available in the following concentrations: U-40, U-80 and U-100. Syringes with both U-40 and U-80 scales frequently lead to errors in administration; the patient may inject either twice as much or one-half as much insulin as he is supposed to receive. The multiplicity of strengths of insulin available may also lead to errors. Even nurses giving carefully prescribed doses to hospitalized patients may become confused by insulin syringes which have two scales. For this reason the single scale insulin syringe should always be recommended.

It is now possible for even a blind diabetic to administer insulin to himself. The B & D Improved Cornwell syringe, No. 1250, has been on the market for many years. The gauge is set at the desired dose by the physician and the blind patient can inject his insulin automatically. A magnifying lens clamped to the syringe was developed by a Cleveland nurse (Marian E. Tschischeck, 1206 Sunset Road, Mayfield Heights, Ohio) and is another useful aid for diabetic patients with impaired vision.

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Rheumatoid Arthritis Relief

With rheumatoid arthritis intraarticular injections [of steroids] may be helpful adjunctive therapy when one or two joints are not responding to systemic therapy.—Abraham Cohen, M. D., Philadelphia: *Modern Medicine*, 27:39, Aug. 15, 1959.

Facts About Diabetes

Diabetes, which ranks seventh in the list of causes of death by disease, is a chronic condition which develops when the body can't use some of the food you eat, especially sugars and starches. Diabetes can be fatal unless properly treated.

It is estimated that there are more than two million diabetics in the United States, and almost half of that number are unaware they have the ailment. In other words, one person in every 80 in this country is a diabetic.

Approximately 4,750,000 other persons living today are potential diabetics, which means that they will develop the disease sometime during their lives. About 65,000 persons become diabetic each year.

Diabetes is hereditary. Of the total population of the United States, 40 million persons—or one out of every four persons—are believed to be diabetic "carriers." The disease has been encountered in a 9 day old boy and in a 99 year old woman.—*American Diabetes Association, Inc.*, New York 17, N. Y.

Surgical and Medical Treatment of Peripheral Arterial Embolism

Recent advances in surgical procedure, such as the use of multiple arteriotomies and the reverse flushing technique, are major contributions and have been justifiably well publicized. Of almost equal importance in our opinion is recognition of the value of heparin. Long advocated by Murray, this drug is in a class by itself among the anticoagulant agents. Recent work by Williams provides laboratory confirmation of this clinical impression.

Preoperatively, heparin may extend the critical interval between lodgment and removal of the embolus by prevention of distal thrombosis and thus permit an operation to be performed successfully at a later time than would be possible without it. During the operative procedure, its local use is of immediate value, and postoperatively it offers some protection against clotting in the period of time during which it is necessary to control coagulation by prothrombin-depressant agents.

Finally, although difficult to prove, it is our impression that some desperately ill patients with major arterial emboli may be treated with heparin alone, with the expectation that a certain per cent of the limbs will survive, despite the fact that the function may be impaired.—Raymond J. Krause, M. D.; John J. Cranley, M. D.; Leonardo M. Baylon, M. D., and Edward S. Strasser, M. D., Cincinnati: *A. M. A. Arch Surgery*, 79:285, Aug., 1959.

Diabetes Mellitus — Associated Ophthalmic Changes*

IRA A. ABRAHAMSON, JR., M. D., and IRA A. ABRAHAMSON, SR., M. D.

WHILE the modern treatment of diabetes mellitus through control of diet and insulin has resulted in longer life expectancy, it has not lessened the ocular changes to any appreciable degree. On the other hand, the presence of diabetic retinopathy has little significance as to the longevity of an individual but it has great importance when one considers the visual damage and even blindness that can result from this disease.

As "the eye is the window to the brain," the physician who learns to use an ophthalmoscope and employs it routinely will be richly rewarded, for in this systemic disease, as well as in a great many others, the earliest evidence of disease may be seen in the fundus of the eye. Ophthalmologists in particular, during a routine examination, are frequently the first to detect early pathological changes suggestive of diabetes long before the patient is aware of it.

Diabetes is often present for many years without noticeable symptoms or signs. Associated conditions, such as peripheral neuritis and ocular disease may be the first manifestation of the underlying diabetes. The principal changes associated with diabetes are those involving the retinal venules, however, other structures may also be affected. Recently some experimental work on the bulbar conjunctival vessels disclosed significant vascular changes, e. g. venous distention and arteriolar narrowing characteristic of diabetes when viewed with a stereoscopic dissecting microscope.¹ Other structures, the cornea, aqueous, iris, lens, vitreous and optic nerve may at times be affected.

A. Retina

In the retina the earliest visible vascular change is that noted in the veins which appear to be distended or overfull and occasionally darker in color (Fig. 1). The congestion in the venous-capillary system results in out-pouchings of the venous capillaries, which we recognize as micro-aneurysms (Fig. 2). These small round micro-aneurysms, which look like punctate hemorrhages, are found as an early change along the course of the superior and inferior temporal veins. Associated with this process of venous congestion is the formation of thrombi which may occur in the branches of the central retinal vein (Figs. 3, 4), or the cen-

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tral retinal vein itself (Fig. 5). Symptoms of blurred vision or field defects will result from a branch occlusion while sudden loss of vision may be the result of thrombosis of the central retinal vein. These symptoms are responsible for bringing the patient to the ophthalmologist, whose examination will first disclose changes in the fundus significant of diabetes.

As the disease progresses, the micro-aneurysms in the macular area may rupture or blood may escape from the walls of the deeper set vessels producing rounded hemorrhages in the retina rather than superficial flame shaped hemorrhages seen in hypertension. Symptoms of blurry, fuzzy or smoky vision or sudden loss of vision may result from the occurrence of this hemorrhage. With the absorption of the hemorrhages, lipids and cholesterol are deposited in the retinal layers and first appear as yellowish or white waxy or hard exudates, slightly elevated having discrete margins (Figs. 6, 7, 8).

As the exudates are deposited around the perimacular area, they may be well defined or coalesce and form a ring called *circinate retinopathy* (Figs. 9, 10, 11) or a circular exudate surrounding the macula. These exudates are almost pathognomonic of diabetes, and are in marked contrast to the fluffy white soft exudates seen with hypertension. When hypertension does complicate the picture, cotton wool patches are formed and the veins themselves become ensheathed.

B. Vitreous

In diabetics of long standing, hemorrhages into the vitreous itself may occur and recur causing sudden loss of vision. As the hemorrhage is ab-

*Read in part before the Cincinnati Diabetic Council, Cincinnati, Ohio, March 31, 1959.
Submitted August 4, 1959.

sorbed, neo-vascularization, fibrosis and gliosis develop in the vitreous producing bands or strands called *retinitis proliferans* (Fig. 12). This is a very grave sign as the changes are usually irreversible and once vision is impaired from the retinitis proliferans, it is usually permanent. Since the bands are adherent to the retina, they may contract and pull the retina away from the choroid producing detachment of the retina (Fig. 13). This type of retinal detachment (Fig. 14) is a very serious

complication and usually responds poorly to any form of ophthalmic therapy.

C. Lens

The physio-chemical changes occurring as a result of variations in the blood sugar concentration probably account for changes in the refraction of a diabetic patient by alteration in accommodation of the lens. This may also account for the large number of cataracts occurring in diabetics, as the



FIG. 1. Distended veins.

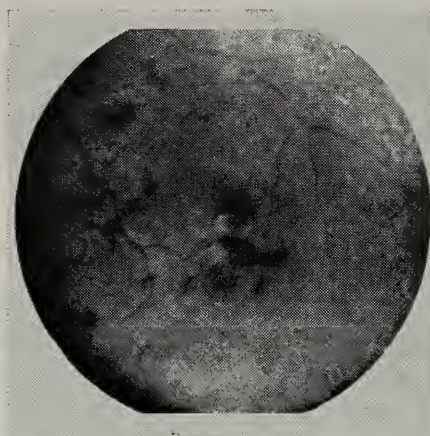


FIG. 2. Micro-aneurysms and hemorrhages.

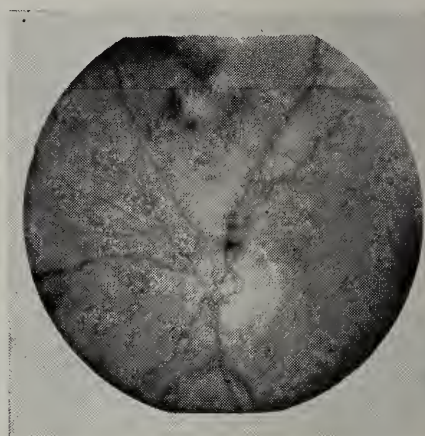


FIG. 3. Thrombosis temporal branch central retinal vein.

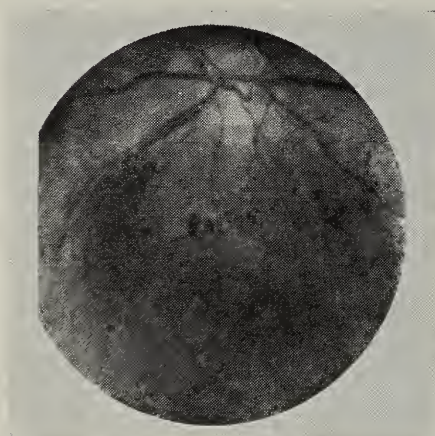


FIG. 4. Thrombosis of branch of central retinal vein.

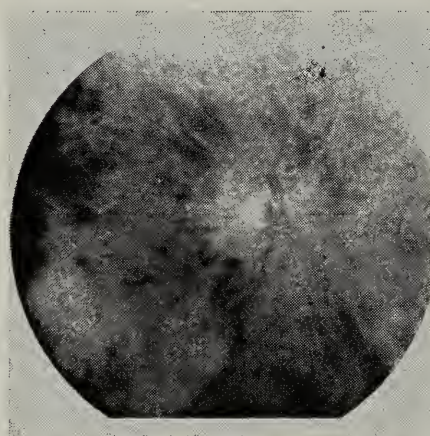


FIG. 5. Thrombosis central retinal vein.

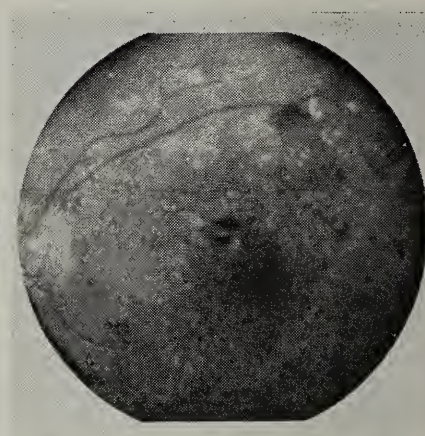


FIG. 6. Micro-aneurysms and exudates.

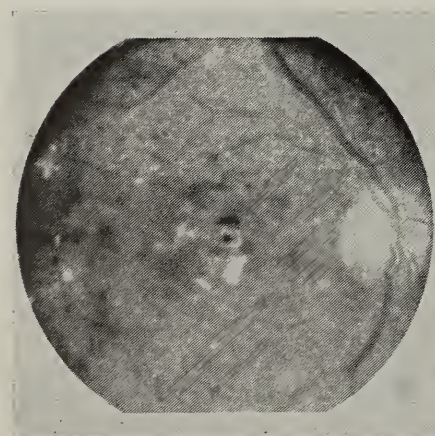


FIG. 7. Micro-aneurysms and exudates.

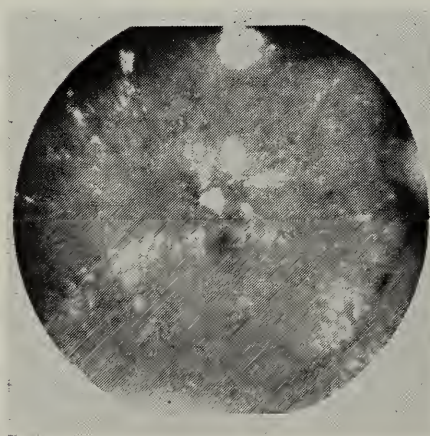


FIG. 8. Distended veins and exudates.



FIG. 9. Circinate exudates.

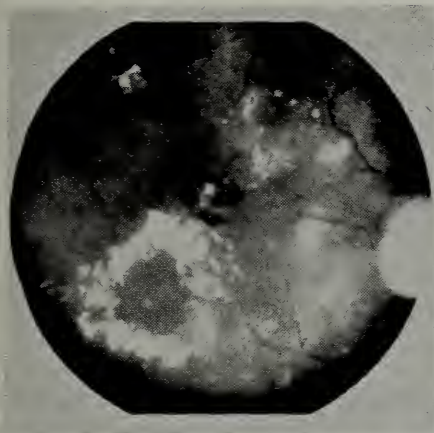


FIG. 10. Circinate exudates.



FIG. 11. Circinate exudates.

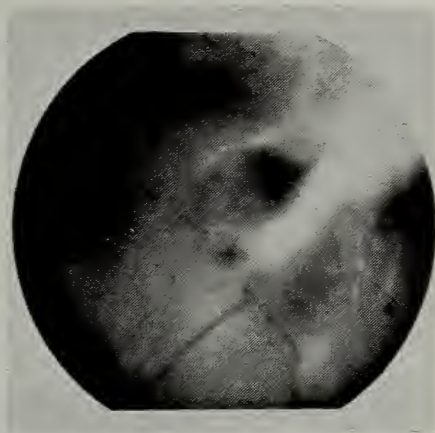


FIG. 12. Retinitis proliferans.

lens is an avascular structure which obtains its nourishment from the aqueous. When the aqueous is altered, the lens metabolism is also altered. Thus an early sign of diabetes may be crumb-like opacities on the posterior subcapsular surface of the lens (Figs. 15, 16). These lens opacities produce symptoms of blurry, foggy, or smoky vision, and rings or halos around lights, which often is the reason the patient comes to seek help. These cataracts are similar to the cataracts occurring in older people, called senile cataracts with the exception that they occasionally occur in youthful diabetics and progress more rapidly.

Another form of diabetic cataract is the white cortical type (Fig. 17). In this case blood sugar is usually elevated causing the lens to imbibe aqueous resulting in clouding of the lens. In the early stages of this form of cataract with a high blood sugar, the patient is usually slightly myopic while in contrast with a low blood sugar the patient is usually hyperopic. Thus this particular individual will have frequent changes in his vision and if examined at these particular times, will have changes in his refractive error necessitating different glasses. In such circumstances the ophthalmologist suspects diabetes.

Cataracts occurring in diabetics should be removed when visual impairment is such that the individual is unable to perform his normal duties. In young diabetics, cataract surgery has been delayed in the past because the lens was firmly held in position by strong elastic zonules. With the introduction of a new enzymatic drug called alpha-chymotrypsin, which has been advocated for lysing the zonules to facilitate lens removal, the operation is now performed at an earlier date. The operation,² like in an adult, is painless and if the retinal function has not been impaired by further diabetic retinopathy, the patient should regain good functional vision with a cataract glass following lens removal. However, it should be pointed out to the

patient before surgery, that even if the cataract is successfully removed, vision may not be perfectly normal as hemorrhages or other forms of diabetic retinopathy may impair the final visual function.

D. Nerve Involvement

Other complications such as papillitis or optic neuritis, accompanied by central scotoma may also



FIG. 13. Retinitis proliferans.

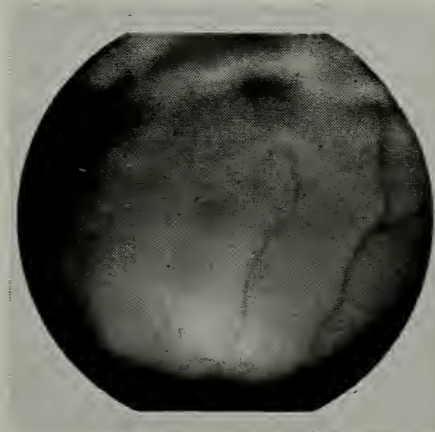


FIG. 14. Retinal detachment.

occur with diabetes. Complete third nerve palsy may also occur producing paralysis of extra-ocular muscles but sparing the pupil. The sixth nerve

may also be involved in diabetes and may or may not recover function. Fifty per cent of the patients who have ophthalmoplegia develop pain. Diplopia is often an annoying symptom and recovery is slow, lasting up to three months.

E. Glaucoma

With the impairment of the venous drainage mechanism, aqueous is unable to be removed from the canal of Schlemm at the same rate at which it is formed and the intra-ocular pressure rises

producing secondary glaucoma. This is a very serious complication of diabetes. Vascularization in the form of new brush-like vessels on the iris (*rubeosis irides diabetica*) (Fig. 18) may take place. Anterior and posterior *staphyloma* may develop (Fig. 19) followed by severe pain, disfigurement (Fig. 20), and total blindness. In such an eye the prognosis is poor and no surgery of any kind, other than enucleation, should be attempted.

With regard to general therapy, there are two schools of thought; one feels that the severity of

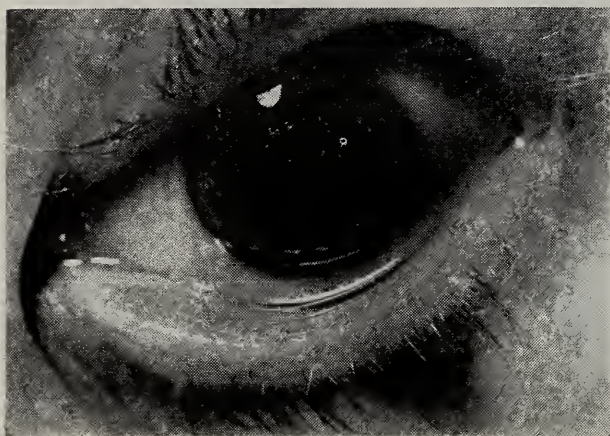


FIG. 15. Crumb-like opacities on posterior subcapsular surface of the lens.

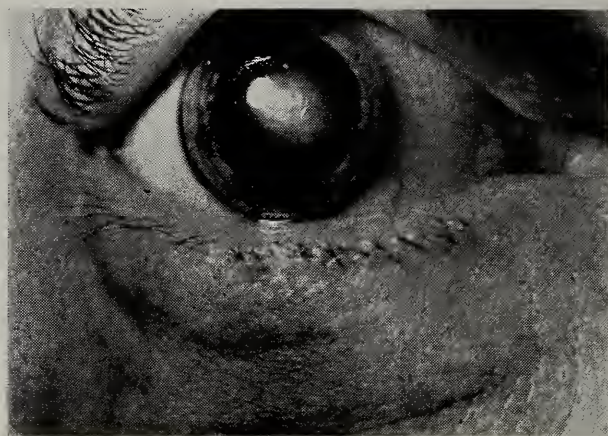


FIG. 16. Advanced cataract complicata.



FIG. 17. Mature and cortical cataract.

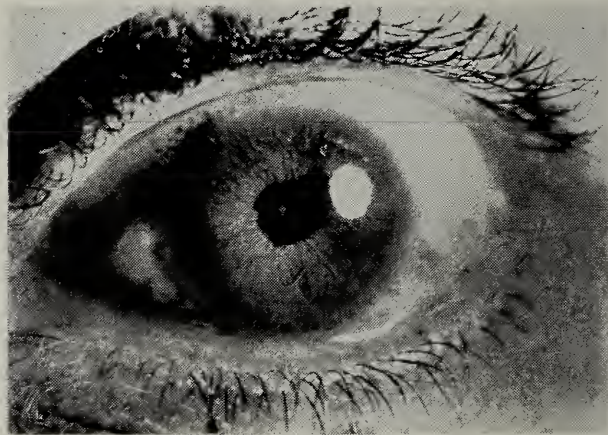


FIG. 18. Rubeosis irides diabetica.

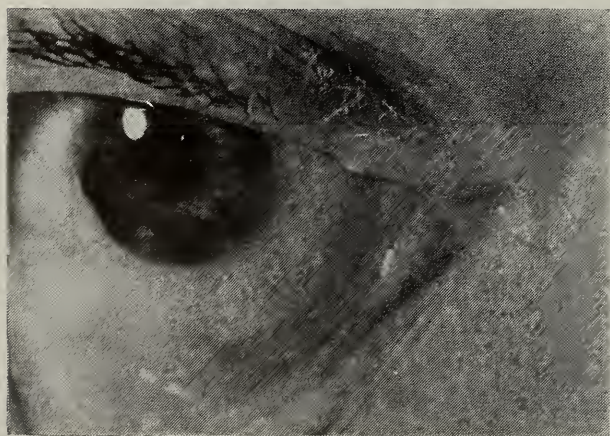


FIG. 19. Absolute glaucoma with anterior staphyloma.

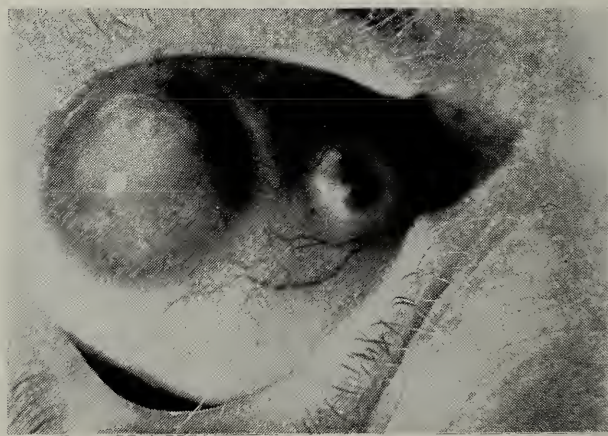


FIG. 20. Absolute glaucoma with corneal leukoma and anterior staphyloma.

diabetic retinopathy depends upon the control of the blood sugar. The other school feels that regardless of the control of the diabetes, the diabetic retinopathy progresses. Which is correct, we are not at liberty to say. However, we do know that the longer the individual has had diabetes, the more chance he has to develop diabetic retinopathy, cataracts or any of the other complications of this systemic disease, and once established, these complications usually become unfortunately irreversible.

Summary

Diabetes is a systemic disease which can be diagnosed earlier by the astute physician during a routine ophthalmoscopic examination. The venous capillary system is involved with fullness and congestion of the retinal veins leading to microaneurysms, hemorrhages, exudates and other complications as presented. Symptomatology and pathophysiology of these and other complications which may then develop are discussed.

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Chemoprophylaxis of Metastatic Seeding During Surgery of Wilms Tumor

Actinomycin D is a potent carcinolytic agent in Wilms Tumor. Its effect is almost constant in small lung metastasis. Various authors have shown blood invasion of malignant cells during surgery of different malignant tumors due to unavoidable manipulation. Thus, it seems logical to try to destroy these cells at the time they are just dislodged from their natural environment and before they are settled.

A tentative prophylactic program with Actinomycin D was designed and used in nine patients with Wilms tumor during the last year. It is too early to draw any conclusions due to the small number of cases and wide variations of mortality at different patients ages, but the program seems worth while to be considered seriously either for an individual case or for a cooperative study.

In order to evaluate the results as soon as possible, a different concept of curability than the "five years without recurrence" was accepted and confirmed in our own series of 48 cases and is suggested to be used for others to test its reliability and usefulness.—Summary of paper presented at OSMA Annual Meeting, April 22, 1959, in Columbus, by Alejandro Aquirre, M. D., Professor of Pediatrics, National University of Mexico.

Absenteeism in Industry Among Diabetics

The diabetic employees at this refinery (Esso Standard Oil Co., Baton Rouge Refinery) seemed to be able to work as efficiently as the nondiabetic employees. The sickness-absenteeism of the diabetic employees averaged 9.8 days per year, which was only one day more than that of the average refinery employee during 1956.

The diagnosis of diabetes mellitus had been established for 90 (1.3 per cent of the 7,140 employees at the refinery; all of the diabetics were men, although there were 282 female employees. During the 774 man-years of observation, only one employee experienced diabetic coma, eight had documented episodes of precoma or acidosis, seven employees had a total of 10 insulin reactions sufficiently severe to result in time lost from the job, and 18 employees reported that they occasionally had mild insulin reactions which did not prevent their continuing on the job.

Cardiovascular complications were responsible for a significant amount of disability in the diabetic employees. Twenty-two of the diabetic employees worked with medically imposed restrictions, usually because of degenerative conditions associated with diabetes but never because of diabetes per se.—(Abstract): Weaver, Neill K., and Perret, James T., Baton Rouge: *Southern Med. J.*, 52:214-218, February 1959.

Diabetics as Employees

A study of approximately 27,000 employees of this oil company (Esso Standard Oil Company, New York) showed that 1.3 per cent were diabetic. The importance of an adequate occupational health program was confirmed by many of the data. The findings provide useful clues to job placement of younger diabetics who seek employment; diabetes does not preclude productive employment, but the man should not be put on a job where normal advancement requires rotation through assignments requiring shift work or requiring the operation of motor vehicles or fast-moving or heavy machinery.—(Abstract): Wade, Leo, M. D., New York City: *Diabetes*, 8:143-148, March-April, 1959.

Femoral Shaft Fractures

In general, most shaft fractures can be adequately treated by closed methods utilizing skeletal traction. Internal fixation with an intramedullary nail or slotted plate is indicated in selected cases. The intramedullary nail has, to a great extent, replaced plate fixation of femoral shaft fractures.—R. F. Neumann, M. D.: *J. Lancet*, 79:385, September, 1959.

Palliative Treatment of the Itching Crisis Of Neurodermatitis

J. W. CALVERT, M. D.

ALTHOUGH the primary effort in treatment of neurodermatitis should be directed toward an etiological approach and permanent eradication, it is important to relieve the itching crisis so that further aggravation by the patient will not retard the gradually improving course which is desired.

Nerve endings between the cells of the epidermis are those concerned with itching.¹ Relief of irritation of these superficial structures should control the sensation of itching. Control of vasodilation is also important because this provides less chance for liberation into the tissues of injurious agents, which, depending on the amount released,² lower the pain threshold and produce itching or spontaneous pain. The following plan of therapy was devised with these two principles in mind.

Plan of Therapy

(1) Ethyl chloride was sprayed on the affected area until complete refrigeration resulted and was then allowed to dry. This resulted both in local anesthesia for instant relief of itching and in a more prolonged effect through cooling of the itching points.³

(2) Tannic acid, 5 per cent in 70 per cent alcohol was applied after the ethyl chloride was dry. This was allowed to dry creating an almost invisible tannate coating.

(3) Aloe vera jelly (A-Gic Jel) was then applied in a coat about 2 mm. thick and allowed to dry, thus creating a transparent modified occlusive coating which allowed one to observe the effect through the coating.

Treatment was instituted in 10 patients with lichenified lesions on the arms and legs varying in size from 2½ inches to complete involvement of the extremities. One patient had edema of the legs and three had a marked erythema of the plaques. The duration of the condition varied from 1 to 10 years and all had received competent treatment previously including x-ray therapy and steroids.

Treatments were administered twice weekly for the first two weeks and then weekly. If there was no improvement having some appearance of permanence after three weeks, additional therapy was started.

Results

There was relief of the itching crisis after each treatment. The relief lasted at least 24 hours and

The Author

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often longer, especially if the patient could be persuaded to leave the lesion alone. In the one patient who had edema, this was improved after each treatment. Erythema observed in three patients disappeared after each treatment, but two required additional treatment. Six of the 10 patients cleared permanently in from 6 to 12 weeks with an average length of treatment of eight weeks. (They were asked to contact me in case of recurrence. This was over two years ago and they have not returned but they have answered correspondence, stating that they are clear at present.) The other four patients have received various additional forms of therapy but, until they were completely clear, they were emphatic in their desire for this form of palliative therapy while submitting to the other forms of treatment.

Summary

A simple local treatment is suggested for the temporary relief of the itching crisis of neurodermatitis.

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Jaundice in Patient Treated With Prochlorperazine

A case of jaundice precipitated by prochlorperazine is reported. The patient was treated first with chlorpromazine for ten months without evidence of jaundice. When the patient received prochlorperazine, clinical as well as laboratory jaundice appeared. The symptoms subsided after withdrawal of this drug. Subsequent laboratory reports failed to demonstrate residual damage. Recovery was uneventful.—Archie Crandell, M. D., and John Y. Ma, M. D.: *J. M. Soc. New Jersey*, 56:553, September, 1959.

Submitted June 10, 1959.

Acute Polyneuritis Following Severe Diabetic Acidosis

RIDVAN R. OZKER, M.D., NELSON G. RICHARDS, M.D.,
and O. PETER SCHUMACHER, M.D., Ph.D.

IN THE PAST YEAR, we have had the opportunity to observe two patients with severe, prolonged diabetic acidosis, who developed acute polyneuritis following resolution of their diabetic acidosis. The first patient developed some difficulty in swallowing and weakness of the intercostal muscles and the second exhibited respiratory embarrassment severe enough that a tank respirator was held in readiness. In both instances, the neuromuscular changes appeared, i. e. low serum potassium in the first case and the persistently low CO_2 content in the second case, as the results of the acidosis cleared. The signs and symptoms of neurologic abnormality gradually cleared during the following two to three weeks.

Before we were aware of this syndrome, our initial impression in the first patient was that the areflexia and weakness were most likely secondary to the hypokalemia. When the areflexia remained with correction of the hypokalemia, and the patient developed facial diplegia, we recognized a separate neurologic element.

In the first patient, we attempted to treat the polyneuritis with ACTH. The course was essentially the same as in the second patient, who did not receive ACTH. The spinal fluid protein was elevated in both instances and returned toward normal with resolution of the neurologic symptoms. Both patients have had complete resolution of their symptoms and have no evidence at present of any diabetic neuropathy or other complications of diabetes.

Case History No. 1

History: Four weeks before her hospital admission, this 29 year old woman observed blurred vision, weakness, and fatigue, which gradually increased up to the time of hospital admission. Approximately one week before admission, she developed nausea, vomiting, headaches, polyuria, and polydipsia. There was no past history of diabetes. On the day of admission, she became lethargic and comatose.

Physical examination at that time disclosed acetone odor of her breath, Kussmaul breathing, blood pressure 80/0, tachycardia, and rectal temperature 98°F. The deep tendon reflexes were absent, and the toe responses were downgoing in this unresponsive patient. Funduscopic examination disclosed no papilledema or diabetic retinopathy.

Urinalysis showed a 4 plus glycosuria with acetone and diacetic acid. Blood sugar was 390 mg/100 ml.

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and CO_2 content was 4.8 mEq/L. Serum potassium was 1.6 mEq/L. and electrocardiographic changes were consistent with hypokalemia.

She was given 500 units of insulin during the first 24 hours of hospitalization and her acidosis disappeared. The hypokalemia was corrected, and the electrocardiogram returned to normal within 24 hours.

Soon after admission, the patient began to complain of numbness in her face, forearms, hands, and less markedly in her feet. She developed left upper and lower facial weakness, tingling in the anterior 2/3 of her tongue, difficulty in focusing her eyes when trying to read, and some difficulty in swallowing. She also complained of generalized weakness. Neurologic examination eight days after admission disclosed transient diplopia by red glass test, mild left upper and lower facial palsy and palatal weakness. The other cranial nerve functions were intact.

At this time, the deep tendon reflexes were symmetrical with 1 plus biceps, absent triceps and brachioradialis, and 2 plus knee jerks. The toe responses were flexor. There was no sensory loss to examination, but there were paresthesias of the lower face and forearms.

Lumbar puncture performed 10 days after admission disclosed an opening pressure of 150 mm. of CSF with open dynamics being found on jugular compression. The cerebrospinal fluid was slightly xanthochromic with five white blood cells, trace of globulin, protein 140 mg/100 ml., Kahn negative, and Wassermann negative.

Two days later, the facial weakness became more apparent on the right side and the deep tendon reflexes began to return. There was no peripheral or facial sensory loss. The neurologic findings of bilateral facial weakness, maximal on the left, CSF protein 140 mg/100 ml., lack of headache, and diminished tendon reflexes with paresthesias suggested acute polyneuritis following severe diabetic acidosis.

ACTH was given intravenously for 14 days. The patient made excellent progress and the facial weakness cleared almost completely after four weeks. One day before discharge, lumbar puncture revealed CSF protein to be 65 mg/100 ml. without cells.

Case History No. 2

History: One month before admission, this 31 year old woman began to have nocturia, polyuria, and poly-

dyspnea and lost approximately 30 pounds in weight. Five days before admission, she developed pruritus vulvae and heavy breathing. She was admitted to a hospital in diabetic acidosis and was treated with a total of 3000 units of regular insulin in the first 24 hours. Blood chemistry reports before therapy included CO_2 20 vol. per cent, urea nitrogen 17 mgm/100 ml., and blood sugar 390 mgm/100 ml. During this time, she developed marked oliguria with a urinary output of from 15 to 20 ml. in 24 hours. She was transferred to the Cleveland Clinic Hospital.

Initial examination disclosed rectal temperature 102°F ., pulse 120, blood pressure 100/68. She was semicomatose and restless. Kussmaul respirations were not observed. Her skin was warm and dry and there was no cyanosis. Fundoscopic examination disclosed no abnormalities. The lungs were clear, the heart and abdomen were not remarkable. The deep tendon reflexes were equal and active. There were no abnormal reflexes and the patient showed no weakness on admission.

The CO_2 content was 8.6 mEq/L. and the blood urea was 120 mg/100 ml. These were gradually corrected over the next several days with fluid replacement and restoration of urinary output.

Six days after hospital admission, she developed marked diffuse muscle weakness, which gradually progressed over two to three days. At the onset of the muscle weakness, it was thought that this may be secondary to hypokalemia as well as acidosis. However, the serum potassium and EKG were normal.

Neurologic examination seven days after admission disclosed marked lethargy with gross orientation and good recent recall. The pupils were 3.5 mm. and equal reacting well to light but not in accommodation. The extra-ocular muscles were intact without nystagmus. The corneal reflex was sluggish but present. Slight bilateral facial weakness was observed. Sensory examination disclosed no gross defect to pin and light touch; and vibration and position responses were slightly decreased in the lower extremities distally. There was no ataxia. There was marked symmetrical proximal weakness of all extremities with diminished muscle tone to palpation and decreased resistance to passive stretch. She was unable to raise her upper or lower limbs off the bed but was able to grip satisfactorily. The dorsal and plantar flexor movements of both feet were moderately strong. The intercostal muscles were weak. No localized muscle tenderness or fasciculations were observed. The deep tendon reflexes were 1 plus in the right arm and 2 plus in the left at the triceps, biceps, and brachioradialis areas with absent knee and ankle jerks. Toe responses were flexor.

On the following (eighth) day, she could raise her right arm above her head with slight improvement in the strength on testing; however, diplopia was present. A lumbar puncture was done nine days after admission. Opening pressure was 140 mm. of xanthochromic CSF with no cells, positive Pandy reaction, protein 280 mg/100 ml., and Kahn negative.

Electromyogram showed mild fasciculations (3 plus) in the left deltoid muscle; however, normal results were obtained in the left biceps brachii, left brachioradialis, right deltoid, right quadriceps, left quadriceps, left outer hamstrings, left gluteus maximus muscles. Manual muscle test showed proximal muscle weakness of the left greater than right and marked weakness of flexors and abductors of both hips, and left shoulder muscles.

On the following day, she began a gradual progressive improvement in her strength and reported a tingling sensation in her feet. Ten days after hospital admission, the facial weakness had almost completely disappeared; but there remained some weakness of the intercostal muscles. A second electromyogram was performed, which was within normal limits. A second lumbar

puncture was performed before discharge disclosing CSF protein 61 mg/100 ml.

She was discharged after approximately three weeks of hospitalization with essentially normal muscle strength of her upper and lower extremities. Two specimens submitted to the Ohio State Department of Health for viral complement fixation studies were reported negative.

Discussion

The etiology of the neuropathy was in question in both patients. If a nonspecific viral illness had precipitated the diabetic acidosis, we felt the neuropathy would have appeared much earlier in the course of the illness. Both of these patients were in good diabetic control on diet and insulin and were afebrile at the time of the onset of the clinical neuropathy. The neurologic involvement was primarily motor with facial diplegia although distal sensory abnormalities were also present. There was a rather rapid return to a normal neurologic picture in both patients. In the second patient, viral complement fixation studies were negative.

Jordan¹ reports one case in which the patient "first noted paralysis after he recovered from diabetic coma." Joslin² et al. describe 12 patients "in which a severe neuropathy developed during or immediately following diabetic coma." In Rundle's⁴ series, one patient developed neuropathy approximately one week following treatment for diabetic coma. Facial paralysis has been reported in three patients in the summated series of 501 patients with diabetic neuropathy by Jordan,¹ Martin,³ Rundles.⁴ All of these patients recovered their facial movements fairly rapidly. Joslin² reports that facial paralysis is the commonest of cranial nerve palsies.

Summary

Two cases of acute polyneuritis with facial diplegia following correction of diabetic acidosis are reported. These manifestations occurred approximately one week after correction of acidosis and hypokalemia. The initial cerebral spinal fluid protein elevation returned toward normal before hospital discharge in both cases. The facial diplegia as well as the other manifestations of neuropathy cleared rapidly in both patients in approximately the same period of time with one patient receiving ACTH daily and the other patient receiving the usual supportive diet, medication, and physical therapy.

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Spontaneous Rupture of the Liver in a Patient With Acute Toxemia of Pregnancy

Case Report

DEMETRIOS RETIKAS, M.D., and NAJIB KARANOUEH, M.D.

SPONTANEOUS rupture of the liver is a rare condition and when complicating pregnancy, is even less frequent. This accident of pregnancy presents a characteristic clinical picture and a very grave prognosis. Only 15 cases have been reported and to these we add the following.

Case Report

The patient, a 37 year old colored woman, in the 32nd week of her fourth pregnancy, was admitted to Mercy Hospital, Canton, Ohio, on Sept. 9, 1957, with complaints of headache, dizziness, nausea, vomiting, associated with slight pain and tenderness of the epigastrium and the right upper quadrant. She had not had prenatal care. Her previous pregnancies had been normal except for the last one six years previously when she developed a kidney infection.

The first examination was at 11:45 a.m. in the emergency room where, in addition to the other symptoms, her blood pressure was found to be 230/120 and the pulse rate 92/m. The lungs were clear, the heart slightly enlarged; but no murmur could be found. The abdomen was soft, and tender in the right upper quadrant, and the pain was radiating to the right shoulder. The uterus was enlarged to the size of 32 weeks' gestation. The fundus was three fingers below the xiphoid process. The fetal heart rate was 110/m, regular in the lower left quadrant. The liver and spleen were not palpable, and there was no evidence of free abdominal fluid.

Vaginal examination presented a soft cervix dilated 1 cm. but no bleeding. Neurological examination was limited to testing of the patellar reflexes which were slightly hyperactive. Urine analysis revealed an orange colored urine, cloudy, with specific gravity 1009, 4 plus albuminuria, but no red cells.

Blood chemistry studies revealed uric acid 11.55 mg./100 ml., nonprotein nitrogen 53.5 mg./100 ml., creatinine 3.8 mg./100 ml. She was admitted to delivery floor with a diagnosis of acute toxemia, possible cholelithiasis.

Half an hour later, the patient complained of pain in the epigastrium; suddenly the blood pressure dropped to 60/0, and 15 minutes later it was unobtainable. Pulse rate was 120/minute, and the patient was in deep shock. The fetal heart rate was absent, but the contractions of the uterus became stronger and more frequent. Vaginal examination revealed 3 cm. cervical dilatation and a small amount of vaginal bleeding. With a diagnosis of abruptio placenta or internal hemorrhage from rupture of the uterus, cesarian section was performed, and a stillborn female infant was extracted.

The abdominal cavity was filled with fresh blood. The uterine wall was intact, but there was a slight separation of the placenta. After completing the section, more fresh blood was found to be coming from the upper abdomen. Examination of the spleen revealed no abnormality, but there was a large transverse laceration about 6 cm. in length on the anterior surface of the left

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lobe of the liver. The anterolateral surface of the right lobe was covered with a subcapsular hematoma. The liver was very soft.

The laceration was packed with Oxycel[®] and sutured with interrupted silk. Two to three interrupted stitches were applied to the inferior surface of the diaphragm to compress it against the liver. Blood pressure during the operation was 100/60, after Neo-Synephrine[®] 4 mg. intravenously, 2 pints of blood and Solu-Cortef[®] 2 cc. had been administered. About 15 minutes after surgery, the blood pressure dropped again to 0. During the next five hours the patient was in shock with blood pressure 0/0, pulse rate 140/minute. The blood transfusion continued, and she was given five pints of blood. At 9:15 p.m. of the same day, a moderate amount of blood was coming through the abdominal incision. She died 10 hours after admission.

Autopsy findings: "The liver weighed 1000 grams. A large hematoma was present below the capsule over the entire anterolateral portion of the right lobe. A 6 cm. laceration was present in the capsule of the left lobe which had been sutured and covered with Oxycel. There were a few stitches between the liver and diaphragm. The parenchyma was very soft; the cut surfaces bulged

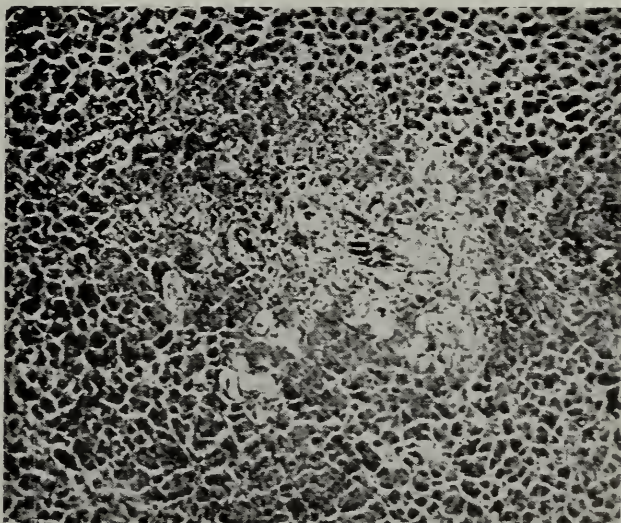


FIG. 1.—Section showing necrosis of the liver.

Submitted May 7, 1959.

and presented a mottled yellow to orange-brown discoloration. The kidneys were moderately enlarged, each weighing 180 grams. The capsules stripped easily. The parenchyma was pale.

The uterus was enlarged, and a transverse incision on the lower segment was closed properly.

"Microscopic examination of the tissues revealed acute focal hepatic necrosis accompanied by minimal inflammatory reaction. The remaining liver cells were swollen and there was fibrous formation in the portal area."

The causes of death were classified as follows: "(1) Acute focal necrosis of the liver with subcapsular hemorrhage and rupture of Glisson's capsule, (2) intraperitoneal hemorrhage with shock, (3) clinically acute toxemia of pregnancy."

Discussion

Spontaneous hemorrhage of the liver may result from the hepatic lesion of acute toxemia. Spontaneous rupture of Glisson's capsule from massive hemorrhage is one of the rarest complications of the disease. No more than 15 cases have been reported, and ours is the 16th.* The patient did

vascular derangements. These lesions may be found in the absence of convulsions and indeed have been found in the livers of patients dying in labor without a history of toxemia. Almost always, specific periportal lesions occur in the liver with eclampsia. These lesions can be readily seen since scanty minute red petechiae are present on the outer surface of the liver. However, the lesions cannot usually be identified on the cut surface.

In severe cases there are numerous petechiae on the outer surface, and on the cut surface there are patches similar to a recent venous congestion of the liver. Formerly, it was thought that the acute hepatic necrosis had as its cause a specific toxin and was regarded as a toxemia of pregnancy. Gradually, however, this view lost ground and it is now believed that there is no such thing as hepatitis peculiar to pregnancy.

Toxemic patients are notorious for their ten-

TABLE 1.—*Reported Cases of Spontaneous Rupture of the Liver During Pregnancy*

Author	Year	Age of Patient	Gravida	Duration of Pregnancy	Toxemia	Convulsion	Vomiting	Trauma	Pain	Result
Abercrombie	1844	35	Term			x	x	x	Fatal
Kosoloff	1914	39	Primipara		x		x		x	Fatal
Herz	1918	41	Multipara	8 months	x	x	x		x	Fatal
Kolisko		24		Term	x	x				Fatal
Duverges	1928	39	Multipara	Term	x	x	x		x	Fatal
Roblee	1940			No details						Recovery
Roemer	1941	30	Multipara	7 months	x	x			x	Fatal
Rademaker ⁴	1943	32		8 months	x		x		x	Recovery
Sanes & Kaminski	1946	26	Multipara	7 months	x	x			x	Fatal
Linkes	1946	42	Multipara	4 months					x	Recovery
Burton-Brown & Shephard	1949	32	Multipara	Term	x		x		x	Recovery
Haller, Abels & Straus	1951	34	Multipara	8 months	x				x	Fatal
Speert & Tillman ⁵	1952	31	Multipara	7 months	x	x	x		x	Fatal
Kramish, Aver, & Reckler ⁶	1952	32	Multipara	Term	x				x	Recovery
Pereyra, Lawler	1953	34	Multipara	8 months					x	Fatal
Present Case	1957	37	Multipara	32 weeks	x		x		x	Fatal

not have any marked trauma or convulsion. However, the question of insignificant trauma during the transportation of the patient from the emergency room to the delivery floor, as well as during palpation or examination, cannot be definitely ruled out.

The liver in toxemia is not necessarily enlarged, and sometimes acute toxemia is associated with yellow atrophy of the liver or hepatic necrosis. Sheehan¹ describes a focal lesion (the periportal necrosis of eclampsia) and a diffuse lesion (hemorrhagic necrosis) of the liver parenchyma.

Primary hepatic necrosis is not very obvious in eclampsia. The lesions are due to predominantly

dency to spontaneous hemorrhage and except for the common hemorrhagic lesions of the liver and the high incidence of premature separation of the placenta, many suffer hemorrhage into the subarachnoid space, into the brain (Welch's patient), into the rectus muscle (Sanes-Kaminski),² and into the retroperitoneum from the pancreas (Ogden).³ The pathological physiology of eclampsia suggests the importance of fibrinogen depletion as the cause of these hemorrhagic phenomena.

In all the reported cases there was pain in the right upper quadrant and several of these have been admitted with a diagnosis of gallbladder disorder. However, patients in acute toxemia with pain of the right upper quadrant and epigastrium

*See Table 1.

and with rapid development of shock should suggest the possibility of rupture of the liver.

The only hope for recovery lies in surgery. But sometimes, as in this case, the repair of the laceration is very difficult because of the consistency of the hepatic tissue. In this instance, a few sutures through the parenchyma, with packing of Oxycel and pressure to the inferior surface of diaphragm was the method used. Difficulty was encountered in placing the stitches because the liver tissue was soft and a new tear was created. The mortality in this type of case, even after surgical intervention, is more than 50 per cent.

The immediate control of bleeding is easily accomplished by digital pressure on the portal vein in the region of the foramen of Winslow. Permanent measures for hemostasis are (a) suture of the damaged portion of the liver; (b) packing of the laceration with Oxycel, fat, muscle, or omentum; (c) electrocoagulation by cautery.

Summary and Conclusion

The sixteenth case of reported spontaneous rupture of the liver with intra-abdominal hemorrhage complicating acute toxemia has been described. The cause of hemorrhage is the hepatic necrosis assisted by hypertension and complicated by trauma such as palpation of the abdomen, convulsion, vomiting, labor, or moving of the patient.

In most of the cases, the hemorrhage is first subcapsular, probably accounting for the right upper quadrant and epigastric pain. The only hope for survival in these patients is the recognition of the complication and its symptom complex followed by surgery. But in severe cases because of the consistency of the liver, the mortality will still be 50 per cent or more.

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Pleural Biopsy

The value of pleural biopsy by both needle and open surgical technique is cited. Results of 106 needle biopsies of the pleura are presented. Twenty-six per cent positive diagnoses were obtained in 88 cases. Specific diagnosis is obtained simply, with minimal trauma to the patient, and with saving of both time and money in shortened hospitalization and fewer diagnostic procedures.—Stanford K. Sweany, M. D., Chicago: *Illinois M. J.*, 116: 123, September, 1959.

Bronchoscopic Aspiration Cures Of Pseudo Bronchiectasis

Pseudo bronchiectasis refers to an apparent dilatation of the bronchi by blunting and incomplete filling on bronchography due to bronchial obstruction by retained bronchial secretions.

The bronchial obstruction is caused by respiratory infections which have failed to clear completely or something which interferes with the normal cough mechanism, such as a chest injury or pulmonary emphysema.

Symptoms of pseudo bronchiectasis are aching pain, pressure or tightness in the chest, inability to take a deep breath, and weakness and dyspnoea on exertion.

Signs of retained bronchial secretions are slight afternoon temperature, dry cough, and increased bronchial markings on chest films.

Bronchoscopic irrigation and aspiration will produce permanent cures in about one third of the patients, seasonal cures in another third and only temporary improvement in those with extensive chronic pulmonary infections and disease.—J. Karl Poppe, M. D., Portland, Ore.: *Northwest Med.*, 58:1255, September, 1959.

What's New in the Treatment Of Ulcerative Colitis?

Surgical treatment becomes necessary in certain patients with ulcerative colitis who do not respond to medical management. As new and less toxic steroid drugs are coming into use, there are fewer surgical indications.

The use of hydrocortisone acetate as a nocturnal retention enema has done much to allay the signs and symptoms of ulcerative colitis. General supportive treatment in the hospital with blood transfusions and sulfa drugs, particularly Azulfidine®, offer much.

A new concept in the surgical treatment of ulcerative colitis is the restitution of intestinal continuity between the ileostomy and the lower rectum following colectomy. Our experience in a relatively small series of patients undergoing colectomy with low ileorectal anastomosis in the last two years would indicate that there is a definite place for this procedure in the surgical treatment of ulcerative colitis. With hope in sight for the avoidance of permanent ileostomy, the heretofore common practice of total proctocolectomy should be supplanted by subtotal colectomy whenever the rectum and sphincter mechanism has not been severely damaged by the disease.—Summary of paper presented during the Annual Meeting of the OSMA in Columbus, April 22, 1959, by Rupert B. Turnbull, M. D., Cleveland.



MATERNAL HEALTH IN OHIO

Case No. 223

The patient was a 28 year old white woman, Para III, abortus I, who died two hours following an outlet forceps delivery. Her only significant past history was of a dilation and curettage following a spontaneous abortion at three months when packing was used to control excessive bleeding. There was no history of difficult labor or delivery with either of her two previous term deliveries. Her present pregnancy was uneventful prior to the onset of labor.

The patient was admitted to the hospital at term, December 5, in early active labor. The membranes had ruptured spontaneously one hour prior to admission. Her labor lasted five hours and was apparently normal, no unusual abdominal pain or persisting pain was noted. About one hour prior to delivery, the fetal heart became perceptibly slower and oxygen was administered. The patient's blood pressure and pulse rate were normal at that time. A saddle block was administered and the blood pressure dropped to 90/60 but the pulse rate remained normal. A markedly asphyxiated but living infant was delivered by apparently easy outlet forceps. Attempts at resuscitation were unsuccessful. The placenta was expressed and a marginal clot was noted.

The blood loss during and immediately following the third stage was estimated at 400 cc. Thirty minutes after delivery, the blood pressure could not be obtained. Vasoxyl® was given and the blood pressure promptly returned to 90/60. Intravenous fluids and dextran were started and one hour and 40 minutes after delivery whole blood was started.

Two hours after delivery, a vaginal examination was done and a rupture of the uterus was discovered extending from the external cervix into the lower uterine segment and into the parametrium. It is not noted how much external bleeding there was during the several hours following delivery. At about the same time the vaginal examination was done, the patient's heart stopped; thoracotomy and cardiac massage were unsuccessful. The patient was pronounced dead, two hours postpartum. Permission for autopsy was obtained.

Pathological Diagnosis: Old, endocervical sutures; fibrosis of cervix; (spontaneous) rupture of uterus, lateral (15 cm.) laceration cervix and lower segment; hematoma of right broad ligament; subserous hematoma of uterus; hemoperitoneum; anemia of liver; pulmonary congestion; congestion of spleen; antemortem thoracotomy (left) and laparotomy.

Comment

This case is of interest because it represents a silent rupture of the uterus apparently occurring at the site of an old cervical laceration, as indicated by the microscopic finding of suture material. Although there was little to arouse suspicion prior to delivery, the excessive blood loss during and immediately following the delivery of the placenta and accompanying shock warranted *immediate ex-*

TOPIC THIS MONTH:

Maternal Deaths* Involving Uterine Hemorrhage

amination of the birth canal. This was not done until two hours following delivery. The Committee voted this a preventable maternal death.

Case No. 239

The patient was a 17 year old colored woman, gravida II, cesarean I, who died undelivered two and one-half hours after admission to the hospital. Her previous pregnancy was terminated by low classical cesarean section for cephalopelvic disproportion following a long labor at term. Her postoperative course was uneventful.

The patient had no prenatal care during this pregnancy and appeared at the hospital December 18, in active labor apparently at term. Despite the fact that the patient was noted to be "restless and confused" and that the nurse was unable to obtain a blood pressure, the pulse rate was normal and the abdomen was soft. The contractions were irregular and x-ray pelvimetry was obtained. Although several additional attempts to obtain a blood pressure were unsuccessful, the pulse rate was recorded as 80 per minute and it was not until two hours and 15 minutes following admission that the patient was observed to be in shock. Coramine® was given but the patient died undelivered two and one-half hours after admission. Autopsy was done.

Pathological Diagnosis: Ruptured uterus at term; hemoperitoneum. Autopsy showed a 15 cm. laceration of the uterus at the site of the previous cesarean section. The 3500 gram baby was lying free in the abdomen and there were 3000 cc. of blood in the peritoneal cavity.

Comment

From the information available, it appears that there was no recognition of the impending disaster until 15 minutes before the patient's death. No measures to combat shock were undertaken except the administration of Coramine. In such cases of previous section for a permanent indication, the

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by official representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

commonly accepted practice is to avoid the risk of labor by elective section or to do the section *immediately* should labor begin prematurely. Such patients are watched closely and a rupture of the uterus anticipated. It is likely that an elective section could have been planned had the patient presented herself for prenatal care. The Committee voted the case a preventable maternal death.

Case No. 303

The patient was a 21 year old white primigravida, who died three hours postpartum. Last menstrual period July 26, she registered in her fifth month. Her past history was not significant and she had an entirely normal prenatal course. On June 12 she was admitted to the hospital in active labor at term and progressed to full dilatation in five and one-half hours with minimal analgesia. The head of the fetus remained at zero station in left occipitoposterior position. Under ether anesthesia a forceps rotation was done without difficulty but the delivery required a hard pull; episiotomy was performed. The living infant weighed *nine* pounds. The placenta was delivered promptly and there was "slightly more than normal bleeding but not excessive"; (500 cc was estimated blood loss).

Ten minutes following delivery, the patient went into shock and vaginal examination revealed a laceration of the left vaginal fornix. This was repaired but the state of shock continued to deepen despite supportive measures. One hour and 40 minutes were required to obtain blood. An abdominal exploration was done and no intra-abdominal bleeding was found. A hysterectomy was performed. The patient continued in shock and expired three hours postpartum. Autopsy was done.

Cause of Death (certificate): Cardiac arrest; postpartum shock; lateral fornix tear.

Pathological Diagnosis: Massive retroperitoneal hemorrhage (full report not available).

Comment

The Committee voted this a preventable maternal death. From the information available, it cannot be ascertained whether the retroperitoneal hemorrhage was present prior to the abdominal exploration nor can it be determined why the hysterectomy was done if external bleeding was not excessive. Although spontaneous retroperitoneal hemorrhage is occasionally observed, the difficult delivery and the laceration of the fornix suggests that in this case it was due to trauma.

* * *

These three cases of maternal death due to more or less hidden bleeding demonstrate vividly the insidious nature of some obstetrical hemorrhages. Any uterus which is scarred from a previous section or an old laceration should be expected to rupture. Any difficult delivery, especially one involving extensive manipulation with forceps, calls for immediate examination of the birth canal, looking for possible lacerations. The routine nature of the great majority of obstetrical cases makes it difficult to maintain a constant state of vigilance. None the less, it is only by the establishment of

good habits by all the delivery room personnel that these unexpected catastrophes can be avoided.

Comment of Consultant

The following comment of a consultant, who is a specialist in Obstetrics and Gynecology, was given at the request of the Committee.

A constructive discussion of these three maternal deaths revolves itself around the consideration of obstetrical hemorrhage due to ruptured uterus and cervical laceration from the standpoint of prophylaxis, early recognition and adequate management. With good prenatal care, the obstetrician and the patient have a needed advantage and a protective reserve. Once labor has begun, prophylaxis of hemorrhage demands anticipatory thinking.

In considering the subject of uterine rupture, spontaneous or traumatic, laceration of the cervical portion of the uterus is the most common site of parturitional trauma. The cervix must be thoroughly inspected immediately after delivery routinely. In all tears, moderate or extensive, reparative surgery and secured hemostasis is mandatory. Rupture of the body of the uterus is one of our most serious obstetrical complications. Immediate laparotomy with adequate blood transfusion is the *sine qua non* of ruptured uterus.

In rupture after a previous section, the symptoms may be comparatively mild at first, most often pain over the site of the previous cesarean scar, and restlessness. There is no method to ascertain the integrity of a cesarean scar or to predict its behavior during labor. I shall continue to adhere to the dictum "once a section, always a section." If the patient, having had a previous section, presents herself in labor, immediate section is mandatory.

When the third stage of labor is associated with blood loss of 500 cc. or over, it must be regarded as postpartum hemorrhage. A liberal attitude toward manual exploration of the uterus in the immediate puerperium is recommended to determine presence of rupture, laceration, or retained placental tissue, and carries no risk if aseptic technique is used.

To avoid uterine rupture, cervical laceration, and fetal trauma, great care must be exercised to accomplish an atraumatic delivery. One must always answer Dieckmann's question prior to vaginal delivery, "Can I deliver from below atraumatically?" If forceps delivery is found to be a "hard pull" the obstetrician should remove the forceps and re-evaluate manually for possible contraction ring or previously unrecognized disproportion, and consider immediate section instead.

In any case of postpartum hemorrhage or shock, treatment must be immediate and vigorous including oxygen, intravenous fluids, blood transfusion as

soon as possible and immediate inspection of the birth canal and uterus for lacerations, rupture, atony and retained secundines. The patient's blood may need to be checked, clot retraction time, etc., for presence of hypofibrinogenemia or some other generalized bleeding disorder whereby hysterectomy may simply shift the site of bleeding to other areas.

The circumstances in all three cases show *lack* of early *recognition* of cause and inadequate delayed therapy.

Case No. 223: It is my opinion that more attention to the evidence of fetal distress before delivery would have suggested a section. After delivery it is safe to assume that blood loss was in excess of 400 cc., necessitating immediate inspection of the birth canal and uterus for cause of hemorrhage and vigorous shock therapy.

Case No. 239: On admission, this patient had evidence of shock and with history of previous section and physical findings, rupture should have been considered. Pelvimetry was contraindicated since immediate repeat section was indicated. Shock therapy was totally inadequate.

Case No. 303: This case of traumatic delivery would have benefited from removal of forceps and re-evaluation for delivery by section. Supportive measures for shock were too long delayed. Manual exploration of the uterus should have been done to rule out laceration of body of uterus and the need of laparotomy for hysterectomy. Retroperitoneal hemorrhage found at abdominal exploration is best treated expectantly.

Air Pollution Relationship To Health and Disease

The tragic toll of death when the polluted air of industrial communities is raised to lethal concentrations by natural phenomena constitutes a plain and simple warning of what can occur. Evidence is also mounting of the deleterious effects of day-to-day exposure to even lower concentrations. Continued exposure to air pollutants has been repeatedly linked with the increasing urban incidence rates of bronchitis and other lung diseases, including lung cancer.

It is clear that sulfur dioxide and other irritants in the air are poorly tolerated, particularly by the elderly and by those who already suffer from some form of respiratory or cardiac disorder.

So far, this disease of civilization is outstripping all efforts to cure it. In spite of what is being done, the trend is still upward, as industrialization and population increase.—Alvan L. Barach, M. D., New York City: *Bull. New York Acad. Med.*; 35:493, August, 1959.

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEFFEL, M. D.
Columbus, Ohio, Chairman

Following is the summary of a case which was discussed before the Franklin County Pelvic Cancer Delay Committee on September 15, 1959, at its regular monthly meeting held at the University Health Center.

Case No. 73. The patient is a 34 year old white woman, gravida V, Para IV. When first seen at this hospital she was at her eighth month of gestation. At the beginning of the fifth month of her pregnancy, this patient developed some vaginal bleeding. She was examined by her physician and was told that she had a small laceration of the cervix. She continued to have daily spotting.

Due to the absence of her own physician, the patient was seen by another physician who did a pelvic examination and discovered a friable fungating mass on the posterior lip of the cervix. In spite of the softness of the cervix due to pregnancy it was felt that the tumor had extended into the right fornix.

A clinical diagnosis of Stage II carcinoma of the cervix was made. The patient was admitted to University Hospital immediately and a biopsy revealed a poorly differentiated squamous cell carcinoma of the cervix.

Comments

DR. EZELL: This represents the forty-sixth carcinoma of the cervix associated with pregnancy that we have registered in the tumor clinic. Gross inspection revealed a fungating mass on this cervix and one must assume that the lesion was present at the time of the first examination at the fifth month of this patient's pregnancy.

DR. ULLERY: Treatment indicated in this case is to empty the uterine cavity via the cesarean section route. It is essential to avoid as much trauma to the cervix as possible. External x-ray therapy with a midline lead strip screen over the incision should be started on the fourth postpartum day. After involution occurs, central therapy to the cervix should be given.

DR. HOLLENBECK: Even if this lesion were missed on gross examination certainly papanicolaou smear should have indicated its presence if the smear had been taken. It looks as if we must now routinely take papanicolaou smears on all patients reporting for prenatal care.

DR. ZARTMAN: Routine papanicolaou smears in prenatal patients are now taken for granted.

DR. HOLZAEFFEL: *Patient delay:* zero; *physician delay:* at least eight months. This patient's prognosis is reduced from 60 to 20 per cent—five year survivorship.

A Clinicopathological Conference

Edited Under the Auspices of the Ohio Society of Pathologists

CHARLES BLUMSTEIN, M.D., *President*

Presentation of Case

THIS 37 year old white man was admitted to University Hospital, Columbus, three years ago for the first time, with the chief complaint of being drowsy and moderately confused. He had been known to have diabetes since the age of 9. His diabetes had been difficult to control. He had required as much as 1000 units of insulin in a 48-hour period to control his diabetic acidosis. During the two to three years preceding this admission the patient had had chronic pyelonephritis which responded poorly to numerous antibiotics.

The patient on admission was very thin and complained of severe thirst and dry mouth. His breath was acidotic. There was a marked phimosis of his penis, which appeared infected. Repeated blood sugars varied between 1370 and 84 mg.; his CO₂ combining power was 13 cc. per 100 cc. He left the hospital after five days of intensive successful treatment of his acidosis.

One year later the patient was readmitted for persistent purulent drainage in the area of the prepuce or urethra. This had been persistent for approximately 2½ years and intermittent for approximately four years. He had taken several courses of broad spectrum antibiotics with some improvement but never with complete resolution. A purulent discharge was noted coming from beneath the prepuce. After evaluation of his diabetic status, the patient was taken to surgery and a dorsal slit of the prepuce was done under caudal anesthesia. A large amount of purulent material was discovered and drained. Postoperatively, he did well and was discharged on chloramphenicol.

One year later he was readmitted because of swelling and purulent drainage from the toes of his right foot, present for several months. One week before admission, while using a heating pad on this foot, he had fallen asleep and awakened to find marked local inflammation. On soaking his foot in warm water this lesion rapidly developed rather large blisters.

Physical Examination

Temperature was 98.6 F., pulse 90, blood pressure 112/70. The patient appeared chronically ill, thin, and pale, but in no acute distress. Vision was decreased. Examination of his eyes

Presented by

- Roger D. Williams, M.D., Columbus, and
 - Colin R. Macpherson M.D., Columbus.
- Edited by Emmerich von Haam, M.D., Columbus.

showed large vitreous opacities, numerous retinal microaneurysms, with few exudates and broad areas of neovascularization and glial proliferation. The chest was clear. The heart had no murmurs. The liver was two fingerbreadths below the costal margin by percussion; the abdomen was otherwise negative. There was purulent drainage from the ventral surface of the prepuce. Pulses in the extremities were 2 plus. The middle toe of the right foot appeared gangrenous.

Laboratory Data

Hematocrit was 31 per cent; hemoglobin 10.9 Gm.; white blood count 19,650 with 83 per cent neutrophils, 16 per cent lymphocytes, and 1 per cent eosinophils. The urine contained 30 mg. of protein, 1 plus sugar, rare coarse granular casts, 15-25 white blood cells and 1-3 red blood cells per high power field. Blood chemistry: sodium 118 mEq., potassium 4.3 mEq., chlorides 85 mEq.; sugar 690 to 33 mg.; CO₂ combining power 42 vol.; blood urea nitrogen 25 mg. Culture of the right middle toe yielded coagulase-positive Staphylococci, many streptococci, and Clostridium welchii. Culture of the prepuce grew coagulase-positive Staphylococcus. Culture of an abscess of the right thigh yielded coagulase-positive Staphylococcus aureus. His whole blood volume determined by the radioactive iodine method was 3290 ml. as compared to a theoretical 4090 ml. His total red cell volume was 940 ml. as compared to a theoretical 1930 ml.

Hospital Course

The lesion on his foot progressed to wet gangrene involving the entire lateral aspect of the foot. A conservative attempt at debridement of the foot resulted in a rather large granulating area which showed no evidence of healing but definite continued local infection. There was complete gangrene of the toes, and on his third

Submitted August 27, 1959.

hospital day a guillotine amputation of all the toes of the right foot was carried out. Since this did not respond with granulation tissue, mid thigh amputation was considered. However, because of good dorsalis pedis pulses a right lumbar sympathectomy was performed, to which he responded very well. He received 1 unit of packed red cells.

On his 73rd hospital day he began to spike a fever and because of this his scheduled amputation was cancelled. He became unresponsive to painful stimuli. There were coarse rales in the right lobe posteriorly and in the left lower lobe posteriorly. The patient appeared dehydrated. His abdomen became distended and bowel sounds were hypoactive. He received 50 per cent dextrose, aminophylline and Amytal® intravenously, penicillin and streptomycin, and was placed in an oxygen tent. He responded fairly well and was well oriented. He was given only 5 units of insulin a day. He had been alert and talking and 15 minutes later was found dead in bed, on his 79th hospital day.

Clinical Discussion

DR. WILLIAMS: We have here a 37-year-old man who was known for at least 28-29 years to have had severe diabetes. In addition we know that for at least three years he had had pyelonephritis which had responded rather poorly to the usual forms of management. He was admitted first about three years ago with infected phimosis and acidosis for which he was treated successfully. Two years ago he was readmitted for surgical treatment of severe balanitis.

His last admission was 79 days before his death. I think we might predict that a diabetic whose last 79 days were spent in the hospital is bound to develop an infection somewhere unless every precaution is taken against it. Several months prior to admission he developed a foot infection for which he used a heating pad. I don't believe a fellow of his intelligence would have burned himself had he not had a loss of sensation in his foot.

Many patients with diabetes develop this loss of sensation in their feet even to the point of complete numbness as you occasionally see with a loss of reflexes. I think this is an important consideration because it brings up the necessity of differentiating between an infection, gangrene, or a trophic lesion, since the management of these three lesions differs.

Following the use of the heating pad the patient developed more swelling, and this is certainly not unusual. If the heating pad is used too vigorously in a patient who cannot feel the

amount of heat, he will develop marked vasodilation, diapedesis of red cells, loss of protein into the tissue, and ultimately, particularly in a diabetic, thrombosis of the small arterioles with tissue gangrene. This does not mean that the diabetic has to have severe arteriosclerosis as the basic cause of his problem. It can start as an infection in itself and if overtreated with heat will lead to thrombosis of small arterioles.

The physical examination at the time of this admission showed that the patient did have good dorsalis pedis pulses bilaterally, and during his hospital course he was always thought to have good pulsations in his feet. The right middle toe at the time of admission was gangrenous and there was a lot of purulent drainage from the ventral surface of the prepuce. This apparently was an infection which had been developing off and on for a long time prior to this admission and apparently had never been adequately treated, although he had been admitted to the hospital before specifically for this.

The laboratory examinations showed that the patient had mild hyponatremia and hypochloremic acidosis, which is part of diabetic acidosis. The examination of his urine suggested renal damage, which together with his slight elevation of blood urea nitrogen and his eyeground changes seems to point to Kimmelstiel-Wilson disease. He also was anemic at the time of admission and had a blood volume deficit of nearly a liter as measured by the radioactive iodine method. It was apparently a deficit in red cell mass. Coagulase-positive Staphylococci were grown from his foot, the right thigh and his prepuce.

I will then summarize briefly by stating that this is a 37-year-old man with long-standing juvenile diabetes, admitted in mild diabetic acidosis. He also has Kimmelstiel-Wilson disease, diabetic neuropathy involving both feet with evidence of almost total loss of sensation to touch and even to pain of both feet, a chronic pyelonephritis, chronic balanitis and gangrene of the right middle toe.

Why should this patient die 79 days later? If he had Kimmelstiel-Wilson disease with beginning elevation of blood urea nitrogen, his survival should have been two to three years. After admission a conservative debridement of the foot was carried out in bed. Three days later, because the gangrenous process had progressed, he had a guillotine amputation of the toes. We should not take three days to make a decision as to whether surgery for the control of infection in a diabetic is necessary. The diabetic does not develop infections any more readily than the non-diabetic. This has been fairly well proven. On

the other hand, once they develop infection there is no question but that it progresses more rapidly and produces a lot more tissue necrosis in the diabetic than in the nondiabetic. This should be watched, because attempts at debridement in the bed simply delay surgery and may make more radical surgery necessary later on.

Early and Radical

His third degree heating pad burn on the lateral aspect of the foot was only partially debrided because it was thought that the tissue was not ready to slough off yet. Subsequently additional partial debridement, or what I would call "picking at the wound," was carried out on numerous occasions on the ward. I have emphasized already that gangrene and infection progress more rapidly in the diabetic. For this reason not only must surgery be more radical in the diabetic but it must be carried out earlier. There is often a great reluctance in the hospital wards to lay a foot or hand or any wound wide open and cut away all dead tissue.

In the past 18 years we have performed 869 operations on 725 diabetic patients and have proved that elective surgery carried no greater risk in the diabetic than in the nondiabetic, and that postoperative infections are no greater in the diabetic than in the nondiabetic. Elective surgery patients constituted the largest group. The second most common indication for surgery has been infection and gangrene.

One has difficulty in differentiating infection and gangrene of the lower extremities in a diabetic because they usually go hand in hand. As I mentioned earlier, you must differentiate between infection and actual gangrene, and secondly you must differentiate the trophic lesions in which mild infection has developed from the actual gangrenous lesion due to arteriosclerosis.

The patient under discussion developed at least an infection in one toe. Whether he developed this because he stubbed his toe and could not feel it and let it progress and develop an infection later on, I do not know, but when he treated his infection he treated it too vigorously because he could not feel his foot, and he at least had a setup for developing a trophic lesion. Most trophic lesions can be adequately debrided, and when adequately debrided they will heal without amputation.

The differentiation between trophic lesions and gangrene is important because amputation is not necessary in the former. When one is dealing with infection one has to control the infection first before one can decide how much has to be removed as far as a definitive amputation is

concerned. With this in mind, the sooner the debridement is carried out, and the more radical it is, the better. As McKittrick, who has worked with Joslin and has written a long book on diabetes, has commented, "Surgery takes precedence over the regulation of diabetes when infection is the problem. It cannot control the diabetes very well, but at least you can keep him out of acidosis when he has an infection and the control of his diabetes is greatly facilitated by removal of the infection. Drainage of a small abscess will decrease as much as one-fifth the insulin requirements of a diabetic patient."

Forty-one days after his initial debridement the patient had a sympathectomy. I cannot tell from the record whether he needed a sympathectomy or not, but he certainly did not need it as badly as he needed further amputation, which is pretty obvious from his ultimate demise. In any event he had a sympathectomy apparently in order to delineate the area in which amputation could subsequently be performed. To my knowledge no one in the recent surgical literature claims that sympathectomy would change the site of amputation in a patient who already had infectious gangrene. It may prevent gangrene in a patient who had impending gangrene at the time, and many of you have seen, I am sure, so-called "paradoxical gangrene" following a sympathectomy.

Labile Diabetes

In about a week or ten days following his sympathectomy he developed temperature elevations and his diabetes became a great deal more difficult to regulate. If one looks through his whole record one finds that his insulin requirement varied almost from day to day. This is rather typical of the labile diabetic, but with enormous increases in insulin requirement one should suspect infection.

I cannot tell from reviewing this large chart just when his systemic infection developed, but three to four days before his demise it was pretty obvious that he had a septicemia and bacteremia. Maybe the large number of antibiotics which he received kept his temperature from rising and kept one from determining when he did have septicemia and bacteremia. He received penicillin, streptomycin, erythromycin, larger doses of aqueous penicillin and finally chloramphenicol, none of which did a bit of good. They probably did prolong his life a few days, but we should not give antibiotics unless the organisms are sensitive to them.

All through this patient's hospital course he continued to have some type of infection in his

foot and he also had an infection from which again coagulase-positive *Staphylococcus* was cultured in the right thigh. Also at least on one occasion this same organism was cultured from the prepuce. Four or five days prior to his demise the patient developed a pulmonary infection, as well as we can tell, and at this point perhaps Dr. Freimanis can tell us how this progressed, because this was another of his many infections.

Discussion of X-Rays

DR. FREIMANIS: The second chest x-ray was done eight days before death when he "developed spiking fever." At this time there was some pulmonary infiltration in the area of the right middle lobe. The appearance was fairly typical of an infectious process, presumably a somewhat localized area of bronchopneumonia particularly in the right middle and lower lobes. It progressed from then on instead of getting better, because the chest film obtained three days before death showed extensive pulmonary infiltration bilaterally. Films of the abdomen were obtained at the same time three days before death and showed massive distention of the stomach, which sometimes occurs in diabetic coma, diabetic acidosis and in a number of other disease entities. There was considerable distention of the small bowel. Fluid levels in the small bowel, stomach and duodenum showed that he had a terminal ileus. So I would say that he had an extensive bronchopneumonia and probably paralytic ileus with peritonitis possibly due to uremia.

Paralytic Ileus

DR. WILLIAMS: We know he had pneumonia, we know it was progressing at the time of demise. I think it was just one more infection that had to do with his demise. We know that he had paralytic ileus. It can occur not only with uremia but it can occur with insulin shock or acidosis, and this man was in and out of both in the days he was alive. So I think this was a paralytic ileus, whether it was due to infection or due to the poor regulation of his diabetes, I don't know. He did not have much uremia. He was not out of electrolyte balance and his highest blood urea nitrogen was 54, shortly after he came in, and then it fluctuated between 5 and 39 during the rest of his hospital time.

I would like to make one further comment: This man obviously needed protein. Prior to his death his hemoglobin had dropped to about 8 Gm. and he was not transfused with whole blood but was given only one bottle of packed red cells. During the time he was in the hospital he received initially a 1500 calorie diabetic diet which was

subsequently raised to 1800 calories. In spite of this he continued to lose weight while in the hospital. His actual caloric intake as recorded on his record ranged between 333 to a maximum of 1946 calories. Most of the time it was closer to the former figure. So he had every reason to be anemic, he had every reason to be hypoproteinemic with inadequate caloric and protein intake and with the infection which he had during his time in the hospital, which in itself will ultimately produce a rather severe anemia. Patients with severe infection, as we learned from the management of burns, will require repeated transfusions during the time they are under treatment for infection and prior to the time the granulating surfaces are covered.

Coronary Artery Disease

Let us finally consider what might have been the cause of this man's death. In my own experience the most common cause of death in surgical diabetics in this hospital has been infection. The second most common cause of death has been cardiac disease. Of six deaths which I know about in the past six years five have had myocardial infarcts. Myocardial infarcts are rather uncommon on the surgical service except in diabetic patients and are practically unheard of in the female patient unless she is a diabetic.

We must remember that coronary artery disease is about as common in the female diabetic as it is in the male. This is not true in nondiabetic patients, where males are more likely to have heart disease. To my knowledge we have not had a postoperative death from coronary occlusion in a patient of this age group. The third most common cause of death in our diabetic patients has been pulmonary embolus. Which caused this man's death? I don't think any of you here would hesitate to write down that infection was the major cause of this man's demise: infection with its associated anemia, malnutrition and failure to regulate an already labile diabetic.

I have not spent any time going into the fact that this man was in and out of hypoglycemia due to hyperinsulinism. This has been our greatest problem on the surgical service: too much insulin with hypoglycemic attacks in the early hours of the morning. To my knowledge we have had very little trouble with acidosis while the patient was on the surgical service, and this patient's attacks were primarily those of hypoglycemia.

His demise was rather rapid and infection played the biggest part in it, and I would predict that this man may well have had multiple abscesses throughout his body. Whether at autopsy they still could culture hemolytic *Staphylococcus*

aureus, I don't know. But certainly infection played a big part. His demise was rapid. The patient had been a few days earlier in a hypoglycemic attack but apparently was doing well except that he refused his supper on the evening when he suddenly died. He was seen by one of the students and a nurse 10 to 15 minutes before his demise. So we know his demise was rather rapid. Rapid deaths do not occur, at least not this rapid, from hypoglycemic shock, and I don't know that coronary occlusion is a very likely cause of this man's rapid death when he had had no previous difficulty and was a fairly young person, although he had had diabetes for a long time.

My guess is that the cause of his rapid death was probably a pulmonary embolus. After having been in bed this long and with this much infection he might well have developed one. Whether it was due to phlebothrombosis or to active thrombophlebitis, I could not state. I would suspect that at autopsy one would also find that this man has arteriolar changes in the kidney and that in addition he has evidence of chronic pyelonephritis. These are to be expected in a patient who has these changes in the urine and an elevated blood urea nitrogen of this degree, and we know that chronic pyelonephritis is a disease he was known to have for at least three years, and it is a fairly common disease in diabetics.

In summary then, we have a patient who had a severe problem of multiple infections which never could be adequately controlled, who never could be amputated because he was never gotten in shape to have it done. His multiple infections continued and were associated with malnutrition, hypoproteinemia and anemia, and he ultimately had a sudden demise while gradually, we might say, going downhill.

Clinical Diagnosis

1. Diabetic gangrene of foot.
2. Bronchopneumonia.
3. Paralytic ileus.
4. Chronic pyelonephritis.
5. Anemia.
6. Septicemia.

Pathological Diagnosis

1. Diabetic gangrene of foot.
2. Bronchopneumonia.
3. Acute purulent appendicitis.
4. Necrosis of pituitary, massive.
5. Chronic pyelonephritis.
6. Septicemia.

Pathological Discussion

DR. MACPHERSON: I don't think there can be any argument but that this man was diabetic

and that his main trouble was infection. The details of his pancreas were difficult to make out because the islet cells showed marked post-mortem degeneration and it was impossible to perform any functional histochemical stains. However, islets were found although they appeared decreased in number. The amputation site was covered with purulent and necrotic debris and the infiltration extended somewhat up along the lateral aspect of the foot. The lesion of his prepuce had apparently cleared.

His lungs showed a lesion which looked more like what we often refer to as an unresponsive pneumonia, that is, the patient has a pulmonary infection but does not show the response of the average person. He had an extensive fibrinous exudation in the lungs but there were singularly few cells in the exudate. If this patient had a leukocytosis before his death I would expect that it would have been an inadequate one.

Another unusual feature of the case was that he had widespread vascular lesions but they were not the type found classically with diabetes mellitus. In diabetes mellitus one usually gets an acceleration of the arteriosclerotic process which one finds as part of the aging process. His large vessels were virtually free of any signs of damage whatsoever, which would be in keeping with the finding of palpable pulses. But widespread throughout the body, in virtually every area except the lungs, he had massive involvement of the arterioles consisting of a hyalinization of the vessel walls. This hyalinization was of the type that one often sees in hypertension but was not of the type which has been described in diabetes as such. But in this man, with his history of diabetes, with the absence of hypertension, with the fact that his heart was of normal size, I think that we have to assume that the lesion was diabetic in origin, and I think it is this lesion that contributed firstly to the gangrene of his foot, and secondly to changes in other organs.

I should mention that he also had ascites of 1000 cc. and small pleural effusions for which I could find no actual cause. He was not in congestive failure, and I think that the accumulation of fluid was probably on the basis of his low protein, or specifically his low albumin, concentration in his plasma.

In the kidney, he did not have Kimmelstiel-Wilson disease but he had evidence of chronic pyelonephritis plus the vascular changes we have mentioned before.

As a complete surprise to us came the lesion we found in his pituitary. Although grossly it did not appear remarkable, it showed extensive coagulation necrosis with a little bit of fibrous

tissue around the necrotic area, a picture commonly described in patients showing Sheehan's syndrome. It was probably this necrosis of the pituitary which contributed to the lability of his diabetes with a sharp drop in his insulin requirement noted on several occasions. It carries, of course, the obvious implication of malfunction of all other endocrine glands associated with the pituitary, and also carries the implication of inefficient reaction to toxic stimuli such as infection and other noxious agents. By estimate, the pituitary was about 60 per cent necrotic. This lesion did not happen 3 to 4 days before death. It is something which must have been there for a considerable period, certainly weeks, maybe months for all I know. It certainly must have influenced his reactive response and endocrine metabolism during his last illness.

In *summary* therefore we have here a diabetic who developed a complication of vascular damage of unusual type. As a result of this, infection and gangrene of his foot and partial necrosis of his pituitary developed. As the result of interplay of these two factors he went from bad to worse; his diabetes became more difficult to control, his infection was not controlled, and terminally he developed other fulminating infections in the lungs, kidneys, and finally in his appendix, where his classical acute suppurative appendicitis was responsible for his paralytic ileus. People with destruction of the pituitary also are inclined to succumb suddenly to infections which in normal persons are not expected to cause sudden death. So although I cannot prove it, I think from the evidence we have available that this is the best explanation for his sudden death.

Liothyronine as a Replacement For Desiccated Thyroid

Liothyronine, a synthetic thyroidal hormone, was evaluated over a three-year period in 166 patients with hypothyroidism. Laboratory studies showed that it elevated a low metabolic rate, but had little effect on proteinbound iodine and generally lowered serum cholesterol level, especially in those whose pretreatment levels were over 300 mg./100 ml. Liothyronine (25 micrograms) proved a suitable replacement for desiccated thyroid (1 grain) and often provided beneficial results in patients whose response to desiccated thyroid had been incomplete. Moreover, its onset and termination of action is more rapid than that of desiccated thyroid; consequently, it is fairly easy to manipulate dosage.—Rita Finkler, M. D., Newark, N. J.: *J. M. Soc. New Jersey*, 56:555, September, 1959.

Treatment of Hirsutism With Prednisone

Giving small doses of prednisone to women with hirsutism has apparently relieved both the hirsutism and the metabolic abnormalities associated with it. The authors confirmed the findings of others that idiopathic hirsutism is due to selective adrenocortical hyperfunction with disproportionate increase in the production of certain hormones.

Five women with the Stein-Leventhal syndrome and 16 women with idiopathic hirsutism were given daily oral doses of 7.5 to 15 mg. of prednisone and had excess hair removed with a wax depilatory at approximately monthly intervals. Clinical results were gratifying, since in all patients the excess hair regrew at successively slower rates and became sparser and finer with each wax depilation. Further hair removal often became unnecessary in three to eight months. The clinical results were rated by the patients as excellent in 11, good in seven, fair in two, and not worthwhile in one.

Urinary hormone levels were determined before treatment and at monthly intervals during treatment. The pretreatment levels of $C_{19}O_2$ 17-ketosteroids were uniformly elevated before treatment, and high values fell in proportion to the dose of prednisone used. The authors believe that it is desirable to keep the daily urinary excretion of total neutral 17-ketosteroids at 8 mg. and the $C_{19}O_2$ fraction under 5 mg. Pretreatment levels of urinary total neutral-17-ketosteroids and $C_{19}O_3$ fractions are not necessarily helpful diagnostically, since they often fall within the normal range despite the presence of hirsutism. Two patients were studied eight months after prednisone treatment was stopped; the total 17-ketosteroids were still within the normal range and hirsutism was still improved.

Transient fatigue was a complaint of about half of all patients treated with prednisone. There were no important side-effects.—(Abstract): Perloff, William H.; Hadd, Harry E.; Channick, Bertram J., and Nodine, John H., Philadelphia: *Arch. Internal Med.*, 100:981-985, December, 1957.

Peptic Ulcer in the Aged

Though commonly thought of as a disorder of the young, peptic ulcer does occur in the elderly and may mislead the doctor who does not think of it. Symptoms and treatment may be somewhat different, however.—Stuart A. Mason, M. D.: *J. M. Soc. New Jersey*, 56:542, September, 1959.

Proceedings of The Council . . .

Heavy Docket of Business Considered at Granville Fall Meeting; Committee Reports Presented; Proposed Amendments Acted Upon

A REGULAR Fall meeting of The Council of the Ohio State Medical Association was held at the Granville Inn, Granville, Ohio, September 18, 19, 20, 1959. All members of The Council except Dr. Geo. J. Hamwi, Columbus, treasurer, were in attendance. Others present were: Dr. Charles L. Hudson, Cleveland, Dr. Carl A. Lincke, Carrollton, Dr. Richard L. Meiling, Columbus, Dr. C. C. Sherburne, Columbus, delegates to the AMA; Dr. Robert S. Martin, Zanesville, chairman of the Committee on Retirement Plan and Welfare Program; Dr. Paul F. Orr, Perrysburg, chairman, Committee on Hospital Relations; Dr. Robert E. Reiheld, Orrville, chairman, Committee on Rural Health; Mr. Wayne E. Stichter, Toledo, legal counsel. Additional guests for certain portions of the meeting were: Dr. Perry R. Ayres, Columbus, Editor of *The Ohio State Medical Journal*; Dr. Ralph E. Dwork, Columbus, Director, Ohio Department of Health; Dr. Anthony Ruppertsberg, Jr., Columbus, chairman of the Committee on Maternal Health; and Mrs. A. C. Colombi, Cleveland, President, Woman's Auxiliary of the OSMA. The administrative staff of the Columbus Office also attended.

On motion duly made, seconded and carried, the minutes of The Council meeting held on May 17, 1959, were approved.

Membership Data

The following membership statistics were presented by the Executive Secretary: OSMA membership as of September 1, 1959—9,096; compared to 9,234 on December 31, 1958. Members of the OSMA affiliated with the AMA as of September 1, 1959—8,144; compared to 8,167 on December 31, 1958.

Prorating and Waiver of Dues

The Council, by official action, adopted the following policy on prorating of dues for new members during the calendar year 1960, and waiving dues for members on extended active duty in the military service or in the United States Public Health Service:

"That dues for new members in practice, affiliating with the OSMA during the last six months of the calendar year 1960, namely, July 1 to December 31, inclusive, shall be \$15.00, one-

half the regular per capita dues of \$30.00. The prorating of dues shall not apply to former members re-affiliating.

"That the following procedures shall apply during 1960 with respect to OSMA annual dues of members on extended active duty in the military service or in the United States Public Health Service:

"1. State Association dues for 1960 shall be waived for members on extended active duty in the military service or U. S. Public Health Service.

"2. State Association dues for 1960 shall be waived for physicians who were members of the Association in 1959 and who enter such services during the calendar year 1960 before the payment of 1960 dues.

"3. A refund of membership dues will not be made if a member enters such services in 1960 after his 1960 dues are received at the Columbus Office of the Association.

"4. The secretary-treasurer of each county medical society shall be requested to cooperate with the Columbus Office in assembling the names of physicians entitled to waiver of dues under the foregoing provisions."

Dues for Interns and Residents

Following a discussion, The Council adopted the following policy for 1960 with respect to dues for members serving internships or residencies:

"Annual Ohio State Medical Association dues in 1960 for a physician serving in an internship or residency program approved by the AMA Council on Medical Education and Hospitals who meets the membership eligibility requirements of the OSMA and who is accepted into membership by a component medical society shall be \$7.50. Such intern or resident shall be entitled to receive *The Ohio State Medical Journal* as a part of his membership privileges."

Reports of Councilors

Detailed reports on activities in their districts were presented by members of The Council. Dr. Mayfield urged Councilors to prepare their reports in writing, if possible, and send them to the

(Continued on Page 1538)

wherever there is inflammation, swelling, pain

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conditions for a fast & comfortable comeback

Host reaction to injury or local infection has a catabolic and an anabolic phase. The body responds with inflammation, swelling and pain. In time, the process is reversed. VARIDASE speeds up this normal process of recovery.

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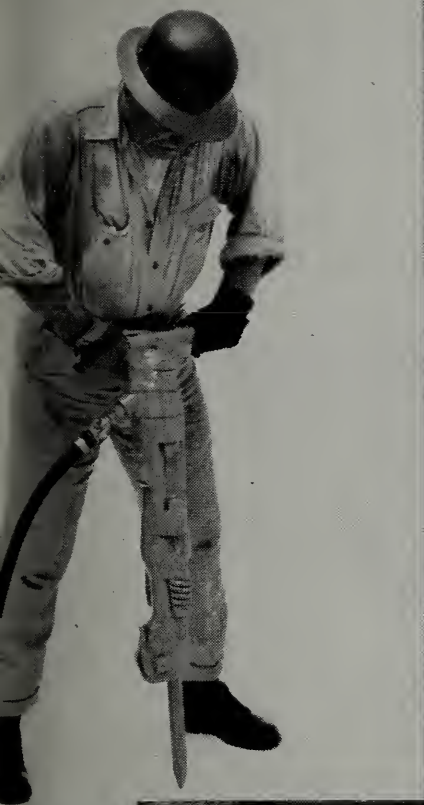
Supplied: boxes of 24 and 100 tablets.

1. Innerfield, I.: Clinical report cited with permission

2. Clinical report cited with permission



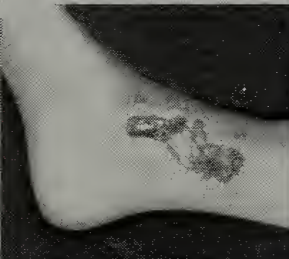
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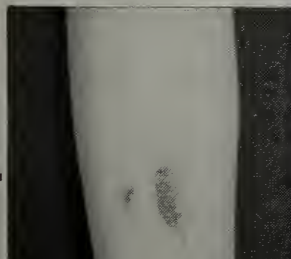
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15 years duration
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**INFLAMMATORY
DERMATOSIS**
rapidly spreading
rhhus dermatitis
healed within
a week¹



**INFECTED
LACERATION**
marked reversal
in 3 days...
returned
to school...
ure advanced¹



THROMBOPHLEBITIS
back on his feet
in a week after
recurrent episode¹



**REFRACTORY
CELLULITIS**
normal routine
resumed after 4 days
of VARIDASE¹



Columbus Office for distribution to members of The Council in advance of each meeting.

Activities of Woman's Auxiliary

Complying with an invitation extended by Dr. Mayfield, Mrs. Colombi, President of the Woman's Auxiliary, appeared before The Council to report on activities which have been carried on by the Auxiliary and plans for the future.

Several specific requests which entail administrative details were presented by Mrs. Colombi and were referred by The Council to Dr. Mayfield and the Executive Secretary for consideration and action.

Amendments Approved

Dr. Pitcher, chairman of the Woman's Auxiliary Advisory Committee, presented on behalf of the Auxiliary a list of changes made in the constitution and bylaws of the Auxiliary at the April annual meeting of the Auxiliary House of Delegates and which must be approved by The Council before becoming effective. By official action, following a discussion, The Council approved such amendments.

Letters of Appreciation

Two letters from Mrs. C. H. Bell, immediate past president of the Woman's Auxiliary to the Ohio State Medical Association, thanking The Council for the financial aid given to the Auxiliary and enumerating the services and activities which were financed by money received from the OSMA, were read and ordered filed.

Committee Reports Approved

Reports of the following committees were received by The Council and approved by official action:

Committee on Scientific Work (meetings on August 30 and September 13).

Committee on Care of the Aged (meetings on May 13, June 17 and September 2).

Committee on Eye Care (meeting on June 28).

Committee on Maternal Health (meeting on July 26).

Committee on Poison Control (meeting on May 27).

Subcommittee on Rural Medical Scholarship (meetings on July 15 and 22).

Committee on Traffic Safety (meeting on June 4).

Committee on Industrial Health (meeting on June 24).

Welfare Fund and Retirement Plan Committee (meeting on June 21).

Welfare Fund

The Council instructed Mr. Stichter to prepare a proposed draft of articles of incorporation and

regulations for a proposed OSMA Welfare Fund organization for consideration by The Council at its December meeting when matters concerning financing of the plan can be considered.

Report by Dr. Reiheld

Dr. Reiheld, chairman of the Committee on Rural Health, supplemented the report of that committee by a verbal report, referring particularly to the preceptorship program and to a plan of the committee to make a careful evaluation of the rural medical scholarship program prior to the December meeting of The Council.

Proposed Amendments to OSMA Bylaws

Following instructions of The Council at its May meeting, Mr. Stichter presented the following draft of a proposed amendment to the Bylaws of the OSMA in conformity with a request made by the House of Delegates at the 1959 Annual Meeting. The resolution, proposing that the following be added to Section 8, Chapter 4 of the OSMA Bylaws, was approved by The Council and ordered presented to the House of Delegates in May, 1960. It read as follows:

"... provided, however, that the Committee on Resolutions shall have the right to amend any resolution so presented or introduced at the opening session, or to draft a composite or substitute resolution embracing the same subject matter as that contained in a resolution or resolutions so presented or introduced, and to submit such amended, composite or substitute resolution for adoption by the House of Delegates, and the House of Delegates shall have the right to adopt any such amended, composite or substitute resolution."

A set of proposed amendments to the OSMA Constitution and Bylaws, setting forth that when a component society incorporates it must secure approval by The Council of its Articles of Incorporation and Code of Regulations, was presented by Mr. Stichter and, by official action, approved by The Council. It authorized presentation of the proposals to the House of Delegates at the 1960 Annual Meeting.

Elks Program Endorsed

A communication from the Ohio Elks Association, asking The Council of the Association to approve the extension of the cerebral palsy program of that Association into 14 additional Ohio counties, was read and discussed. It was pointed out that The Council had approved this program covering 13 counties originally in 1955. By official action, The Council endorsed and approved the extension of the Ohio Elks Association Cerebral



Above are members of The Council and others who attended in an official capacity for the Granville meeting in September. Seated left to right: Dr. C. C. Sherburne, AMA Delegate; Dr. Carl A. Lincke, AMA Delegate; Dr. Richard L. Meiling, AMA Delegate; Dr. Edwin H. Artman, President-Elect; Dr. Frank H. Mayfield, President; Dr. Charles L. Hudson, AMA Delegate; Dr. George A. Woodhouse, Immediate Past-President and AMA Delegate; Dr. Robert S. Martin, Alternate AMA Delegate.

Standing, left to right: Dr. Ray M. Turner, Second District Councilor; Dr. C. L. Pitcher, Ninth District; Dr. H. T. Pease, Eleventh District; Dr. Paul F. Orr, Chairman of the Committee on Hospital Relations; Mr. Charles S. Nelson, OSMA Executive Secretary; Dr. Robert E. Hopkins, Seventh District; Dr. Robert T. Tschantz, Sixth District; Dr. George W. Petznick, Fifth District; Dr. Robert M. Inglis, Tenth District; Dr. Charles W. Hoyt, First District; Dr. W. Wendell Green, Fourth District; Dr. Wm. D. Monger, Ninth District; Mr. George H. Saville, OSMA Director of Public Relations; Dr. Robert E. Reiheld, Chairman of Committee on Rural Health; Dr. Floyd M. Elliott, Third District; Mr. Wayne E. Stichter, OSMA Legal Counsel. Unable to be present was Dr. Geo. J. Hamwi, Treasurer.

Palsy Program to the following counties: Athens, Fairfield, Gallia, Hocking, Jackson, Lawrence, Licking, Meigs, Perry, Pickaway, Pike, Ross, Scioto and Vinton.

OMHA Chemotherapy Program

A request from the Ohio Mental Health Association for approval of a proposed chemotherapy program for persons released from State Mental institutions was discussed at length. It was the opinion of The Council that it needed additional information on this subject. By official action, the Committee on Mental Hygiene was instructed to meet with officials of the Ohio Mental Health Association on this program and to report back to The Council at some future meeting.

Report on Pittsburgh Meeting

Dr. Tschantz reported on a meeting on third-party plans held in Pittsburgh on June 24, having been called by officials of the Tenth Councilor

District of the Pennsylvania State Medical Society. Dr. Tschantz reported that invitations had been extended to the following Ohio county medical societies: Lorain, Trumbull, Mahoning, Cuyahoga and Stark. He said the purpose of the meeting was to consider certain requests made by labor unions for improvements in insurance plans and what action, if any, could be initiated to meet such demands. Dr. Tschantz pointed out that the conference was entirely informative in character and that no official action or commitments were made by those in attendance. The Council accepted Dr. Tschantz's report and thanked him for having attended the meeting in order to bring back information to the Association.

Report on V. A. Medical Program

Dr. Hopkins submitted a report on a communication received from the House of Delegates of the Maryland State Medical Society, which had

been referred to him by Dr. Mayfield for study and a report.

The Maryland letter, relating to the Veterans Administration medical program, made the following recommendations, Dr. Hopkins's report stated:

1. Limit Federal medical care of all veterans to service connected disabilities.

2. Have veterans with service-connected disabilities cared for by the Armed Forces Hospitals or by local civilian hospitals on a Hometown Care basis. U. S. Public Health Service hospitals might also be used to a limited extent.

3. If and when Number 1 and Number 2 are accomplished, a study be made from the State level as to the disposition of the Veterans Administration hospital facilities. Consideration should be given to turning them over to the States, possibly as hospitals for tuberculosis and neuro-psychiatric patients.

The letter goes on to state, Dr. Hopkins reported, that it was the feeling of the Maryland Society that concerted action by the various states and the AMA would result in a Congressional hearing and that the publicity of such a hearing would bring the attention of the tax payers to the situation and would force the Congress to take action.

Dr. Hopkins stated that he believes the ideas expressed in recommendations one and two are laudable and that recommendation three is debatable.

By official action, The Council accepted Dr. Hopkins' report, thanked him for his study of this matter, and took the position that no action appeared to be necessary by the OSMA, inasmuch as the present policy of the OSMA on this matter is that the Veterans Administration program should be confined solely to veterans with service-connected disabilities, which policy is in line with the general recommendations made by the Maryland Society, and because the OSMA policy on this matter was presented to the AMA House of Delegates in 1953 in a resolution sponsored by the Ohio delegates to the AMA.

Columbus Academy Regulations

The Council was asked to pass on Articles of Incorporation and a Code of Regulations for the Columbus Academy of Medicine. Mr. Stichter reported that he had reviewed the Articles and the Code of Regulations. He recommended that the Articles of Incorporation be approved as submitted. Mr. Stichter stated that there were a number of sections in the Code of Regulations which he felt should be changed to bring them into conformity with the bylaws of the Columbus Academy of Medicine. He said, however, that these matters were not serious and that, therefore,

he recommended that the Code of Regulations be tentatively approved, subject to correction based on a memorandum which he had prepared for the Columbus Academy of Medicine for its consideration. By official action, The Council approved Mr. Stichter's recommendations.

Asks For Reissued Charter

A request from the Columbus Academy of Medicine for a reissued charter was approved by The Council and such recommendation authorized for submission to the House of Delegates next May.

Hancock County Constitution and Bylaws

A new constitution and bylaws adopted by the Hancock County Medical Society on May 19, 1959, was approved, providing the society would make several minor changes suggested by Mr. Stichter. The Executive Secretary was instructed to write the Hancock County Medical Society that it should act on such changes at an early meeting and so advise the State Association.

Marion County Constitution and Bylaws

A revised constitution and bylaws adopted by the Marion Academy of Medicine on January 7, 1958, was approved by official action.

Model Constitution and Bylaws for County Societies

The Council was advised that a considerable number of the county medical societies have not as yet adopted the new model constitution and bylaws in order to bring the local documents into conformity with provisions of the OSMA Constitution and Bylaws.

Dr. Mayfield urged all Councilors to get in touch with their county medical societies on this matter at the earliest possible time. He pointed out that revisions were necessary in many instances in order to meet legal requirements and that the model constitution and bylaws would give each local society a clear, definite and workable code of regulations.

Letter on Welfare Cases

A letter from the Marion Academy of Medicine, asking The Council to give consideration to a letter received from Mrs. Mary Gorman, Director, Department of Public Welfare, was discussed. The communication received by the Marion Academy of Medicine read as follows:

"The State Department of Public Welfare is responsible for the supervision of the activities of all governmental welfare agencies in Ohio including the County Departments of Welfare. One

phase of this supervision is to ensure insofar as possible that all recipients of public assistance are accorded the same rights and privileges available to any category of public assistance recipients in each community.

"It has been brought to my attention that in Marion the members of the Marion County Medical Society render services without charge to hospitalized recipients of all categories of public assistance with the exception of the aged poor of the community.

"In conformance with the policy of the Department of Public Welfare that all categories of public assistance recipients shall be accorded the same rights and privileges in the community, it is requested that the members of the Marion County Medical Society render services without charge to recipients of Aid for the Aged who are hospitalized in the Marion General Hospital."

The Council, by official action, expressed the belief that the policy set forth in Mrs. Gorman's letter was not a proper one and that every effort should be made to have the department revise this basic policy. In taking such action, The Council requested the Committee on Care of the Aged to bring up this point with Mrs. Gorman when it confers with her on other matters relating to the Division of Aid for the Aged.

Dr. Mayfield advised The Council that efforts have been started to set up a conference between the OSMA Committee on Care of the Aged and officials of the Ohio Welfare Department, including Mrs. Gorman, the director, and members of the staff of the Division of Aid for the Aged to discuss a number of important questions concerning the AFA medical program.

1960 U. S. Pharmacopoeial Convention

By official action, The Council appointed Dr. Clayton S. Smith, professor of pharmacology at Ohio State University College of Medicine, to officially represent the Ohio State Medical Association at the United States Pharmacopoeial Convention, Washington, D. C., next March, and authorized that he be reimbursed for expenses incurred in attending such meeting.

1960 County Society Officers Conference

The Council designated Sunday, February 21, as the date for the 1960 Conference of County Society Officers and Committeemen, such conference to be held at the Deshler-Hilton Hotel, Columbus.

1960 Conference for Executive Secretaries

A recommendation that there be the usual special conference for full-time executive secretaries

of local medical societies in Columbus on the Friday and Saturday preceding the Conference of County Society Officers and Committeemen, namely, February 19 and 20, was approved.

Committee on Rehabilitation To Be Appointed

Following a discussion of communications from the American Medical Association on rehabilitation and a review of activities in Ohio on this subject, The Council authorized the President to appoint a Committee on Rehabilitation.

Report on OSMA Group Life Insurance Program

The following report was received from the Turner and Shepard Insurance Agency regarding the group life insurance program of the OSMA: As of September 1, 1959, the OSMA Group Life Insurance Plan had 2,500 persons enrolled, consisting of 1,881 members and 619 employees of members. Of those enrolled, 677 had purchased the added \$10,000 coverage and the total amount of insurance in force was \$26,679,400.

It was reported that the agency has completed a re-enrollment campaign in the Fifth Councilor District and is planning to hold a re-enrollment campaign in the Third Councilor District.

Report by Executive Secretary

In his report to The Council, the Executive Secretary covered the following topics:

Activities initiated to bring about a better working relationship between the AMA and various state medical societies and the U. S. Railroad Retirement Board, Chicago, in the handling of disability claim examinations and the payment of services for such examinations.

Actions of Congress during its recent session with special emphasis on the Forand Bill and the Keogh Bill. Activities of the OSMA during the congressional session were enumerated. It was reported that Dr. Dixon, Dr. Artman, Mr. Saville and Mr. Nelson would represent the OSMA at a legislative conference called by the AMA in St. Louis on October 2 and 3.

Cooperation of the OSMA with the AMA in plans for the Conference on Aging to be held in Cleveland, October 28-29.

Information furnished by the Columbus office to Mrs. James E. Fain, Dayton, chairman of the Governor's Commission on Aging.

Informative bulletins which were sent out by the OSMA following the passage of the compulsory immunization law and the newspaper release

on Dr. Mayfield's comments on this law and the Ohio situation generally.

Report of Public Relations Director

A detailed report in writing was presented by Mr. Saville, assistant executive secretary and director of public relations, covering legislative and public relations activities since the first of the year and plans for future activities.

Record of Legislature

Mr. Saville called attention to the lengthy report on the session of the 103rd Ohio General Assembly published in the September issue of *The Journal* and special articles which have appeared on certain laws passed in 1959.

He pointed out that the record of the 103rd stacks up very well from the viewpoint of the medical profession—much better than was hoped for when the legislature convened—and that the legislative machinery of the Ohio State Medical Association had a big job to do this year. He said that a fair evaluation of its performance would be that it clicked very well and that county medical society officers and legislative committeemen in nearly all counties were most effective in making the "back home" contacts. Indications were that they were more active and persistent than usual in conscientiously following through on suggestions for local activity made in the legislative bulletins, Mr. Saville said.

An appraisal of the medical-health legislation enacted, Mr. Saville stated, shows that the record in that field was one of the most constructive in legislative history and that sponsorship of some of these measures and active support of many others by the Ohio State Medical Association enhanced respect for the medical profession around the State House.

District Public Relations Conferences

Mr. Saville reported on the plans which have been made for the eleven district public relations conferences during the next several months and requested members of The Council to do everything possible to stimulate attendance at these important meetings.

AMEF Campaign in Ohio

Reporting for Dr. Merrill D. Prugh, Dayton, chairman of the Ohio American Medical Education Foundation Committee, Mr. Saville presented the following statistics and general information on the AMEF project:

Since the establishment of AMEF by the American Medical Association in 1951 to assist medical schools meet operating expenses, there has been a

substantial increase in the amount contributed by Ohio to the national campaign. In 1951, there were 152 gifts amounting to \$5,735. The Ohio contribution reached an all-time high in 1958, with 1,085 gifts amounting to \$41,651.20. Of this amount, \$15,069 was raised by the Woman's Auxiliary to the Ohio State Medical Association, an accomplishment for which the ladies received a national award.

AMEF promotion also has resulted in greater contributions by medical alumni directly to their own medical schools. During 1958, such gifts by 3,759 Ohio physicians amounted to \$155,871.71. The grand total for Ohio through both sources—AMEF and directly to medical alumni funds—in 1958 amounted to \$197,522.91 from 4,844 donors. A comparable figure for the entire country in 1958 was \$4,154,450.22 from 104,976 contributors. Of that amount 55,246 medical alumni donated \$3,034,405.53 to their own schools, and 49,731 gifts to AMEF totalled \$1,120,044.69. This latter amount includes \$100,000 from the American Medical Association, which also pays all administrative and promotional costs of AMEF.

Mr. Saville stated that a direct mail appeal followed by local solicitation is the pattern which will be followed again by the Ohio AMEF 1959 campaign committee. Dr. Prugh, Mr. Saville reported, earnestly requests the active support of all the Councilors on this matter, as the AMEF Ohio Committee actually consists of The Council of the State Association.

Discussion by Dr. Dwork

Dr. Ralph E. Dwork, Director, Ohio Department of Health, appeared before The Council by invitation. Dr. Dwork gave a detailed report on action of the recent Ohio General Assembly on medical and public health matters. By official action, The Council commended him for the constructive program supported by the Health department.

Report on Maternal Health

Dr. Anthony Ruppertsberg, Jr., Columbus, chairman of the Committee on Maternal Health, presented to The Council the second annual report of the Committee on Maternal Health, consisting of a summary of the study of deaths in 1956, by the committee. By official action, The Council approved the report, commended the committee, and ordered the report published in *The Journal*.

Reports on June Meeting of AMA

Reports on the meeting of the American Medical Association House of Delegates in June, 1959, were presented by the following Ohio delegates:

Dr. Hudson, Dr. Sherburne, Dr. Lincke, Dr. Meiling and Dr. Woodhouse.

Medicare Cases

Several Medicare cases involving dissatisfied patients in the Cleveland area and referred to Council were discussed by Dr. Petznick. He pointed out that he had contacted the physicians involved in such cases and that mutually agreeable adjustments had been made. The Executive Secretary was instructed to convey such information to the military and Medicare officials who had submitted the cases for review.

New Listing in Telephone Company Directory

At the request of the Ohio Bell Telephone Company, Cleveland office, The Council discussed the ethics of a new listing in the company's yellow pages known as the "directional line" listing. It was the opinion of The Council that such listings would not be deemed unethical and would not be considered improper, providing there was no violation of local customs established by the local medical society.

Fifty-Year Awards

Fifty-year certificates and gold emblems for distribution to members entitled to this honor during 1959 were distributed to members of The Council for them to arrange with their respective county medical societies for presentation.

Lake Hope Conference on Physicians and Schools

A communication from the finance chairman of the Ohio Conference on Physicians and Schools, thanking the Ohio State Medical Association for its financial assistance and active cooperation, was read and ordered filed.

Seal of OSMA

By official action, the Council authorized the preparation of a resolution for consideration of the House of Delegates in 1960, authorizing a change in the official seal of the Association. Such change would involve the use of the "Staff of Aesculapius" instead of the "Caduceus" on the seal.

Relative Value Fee Schedules

The Council authorized President Mayfield to name an existing or new committee to make a study of the subject of relative value fee schedules and to report to The Council at an early date.

Ohio Medical Indemnity, Inc. Handbook

A handbook containing factual information, questions and answers and material for talks re-

Immunization Record

The Ohio Department of Health is distributing to local health department supplies of an immunization record card, which will be made available by the local departments on request.

The form is printed on a yellow three by five inch card stock and has spaces for name and address of the child, birth date, sex, mother's name, date and signature of the physician or other certifying agent. The card contains room for information on basic series and boosters for D-P-T; D-T; Diphtheria, Pertussis, Tetanus, Polio, Smallpox, and "Other."

garding Ohio Medical Indemnity was distributed. The handbook had been prepared by Dr. R. Dean Dooley, director of professional relations, OMI.

Sports Injury Conferences

Mr. Page made a report on plans for the four sports injury conferences to be held this Fall at Worthington, Martins Ferry, Cincinnati and Bowling Green, in cooperation with the Ohio High School Athletic Association.

Future Planning Committee

Dr. Meiling made a brief report for the OSMA Future Planning Committee. He stated that several pieces of real estate could be secured by the Association as a site for a future home. He was requested by Dr. Mayfield to bring a further report and definite recommendations at the December meeting of The Council.

There being no further business, The Council adjourned to meet on Saturday night, December 12, and Sunday, December 13.

Attest: CHARLES S. NELSON,
Executive Secretary.

VA Launches New Program To Aid Legally Blind Veterans

Just getting underway at the Hines, Ill., Veterans Administration hospital, is a project to test the usefulness of newer optical aids, such as microscopic and telescopic spectacles, for veterans with service-connected conditions who have so little vision that they are legally classified as blind.

It is hoped the devices will enable many of the veterans to read their own mail, look up telephone numbers, read street and bus signs, and see photographs.

Blinded veterans in Illinois and surrounding states will be given the first opportunities to go to the Hines hospital.

Lorain's Healthorama . . .

Local Medical Society's All-Out Health Education Exhibit Tent at Local County Fair and Sports Injury Conference Draw Much Interest of Public

THE Lorain County Medical Society scored a two-fold hit in public health education and public relations when it sponsored a "Healthorama" in connection with the Lorain County Fair and a High School Sports Injury Conference in Oberlin.

The "Healthorama" was contained in a large tent housing 14 exhibits and two service projects, of such interest that over 15,000 persons went through it during the five days of the Lorain County Fair and fair authorities voted it an outstanding addition to their attractions.

Located in the rural section of the county near Wellington, the Healthorama provided an opportunity of reaching a population with a few physicians and not generally exposed to health education influences.

Service Projects

The major project was the giving of free first polio shots to persons of all ages. Announcement of this was withheld until the Saturday prior to the Fair's opening, but at that time newspapers in the area featured it and the local radio station gave excellent support throughout the week.

The project was staffed by physicians serving two hour stretches from 10 a.m. to 10 p.m. Monday through Friday, and by members of the Woman's Auxiliary who served as secretaries and nurses, giving six hours each. Proper records were kept and transferred to the family's physician at the close. A total of 910 first polio shots were given. Eli Lilly & Company provided a graphic background display.

A Diabetes Detection program, using Clinistix, was run in conjunction with the large Diabetes Exhibit furnished by Lilly & Company. Dr. J. R. Bay, Education Committee member, took responsibility for this project, which was staffed by Auxiliary members. As many as 6,200 clinistix, with full instructions for the test, were distributed. Literature covering all aspects of diabetes and its control was furnished by the Lorain Diabetes Committee.

Food Faddism was augmented by a scale and thousands of persons were weighed and measured during the week, and literature on proper nutrition and weight control distributed.

The otolaryngologists of the Society arranged

for a hearing test section which drew continuous crowds throughout the week.

Drs. R. L. Shilling and Frank Neff arranged a display featuring the latest methods of replacing a lost eye, and also the use of contact lenses.

Drs. Peter J. Ferrato and George H. Hoke, by means of color photography, prepared an excellent exhibit of modern brain surgery, which drew a great deal of attention.

X-Rays were featured with two viewers being set up and films being changed from time to time. The Trauma Committee exhibit was directed towards Traffic Safety. The Poison Committee dramatized the dangers of many common household items, as well as the medicine cupboard, and also incorporated home accidents, with special emphasis on the disused icebox and the plastic garment bag.

Drs. J. M. Strong and G. W. Bennett featured the work of the Gates Hospital for Crippled Children, using effective photography and some of the equipment, braces and crutches used in treatment.

The County Blood Bank, sponsored by the Society, had a colorful exhibit. The Education Committee made available a wide selection of health literature, specially featuring the AMA Family Health Record, and thousands of leaflets were taken.

St. Joseph's (Lorain) and Elyria Memorial Hospitals, who operate training programs, jointly featured "Health Careers"—registered nurses, practical nurses, x-ray and laboratory technicians. Allen Hospital (Oberlin) graphically featured the care of premature infants.

Dr. James T. Stephens, Education Committee chairman, and Dr. L. C. Meredith, secretary-treasurer of the Society, assumed overall responsibility for this project. Education Committee members Drs. J. R. Bay, Charles Butrey, R. E. Hayes, Henry Kleinhenz and William B. Wladecki, gave of their time over months of planning, and each man assumed full responsibility for "Healthorama" during one full day of the Fair—coordinating all services during those 12 hours. Dr. Denis A. Radefeld, president of the Society, was in close touch with all activity.

An ambitious program, its realization was made possible by the active participation of 57 of LCMS members; and 56 members of the Wom-

Principals and Guests at Lorain County Healthorama



Two service projects were major features of the Healthorama. At left, Mrs. H. A. Robinson is giving instructions regarding the use of the clinistix in the Diabetes Detection Program. At right, first polio shots are given to Mr. and Mrs. Dale Nell, Fair officials, by Dr. Denis A. Radefeld, LCMS President, and Dr. Frank H. Mayfield (right), President of the OSMA.



Some of the mainsprings in the Lorain County Healthorama are shown here with distinguished guests:

Front Row, left to right: Dr. H. T. Pease, Eleventh District Councilor; Maurice Brown, State Representative; Michael Lotko, County Commissioner; Dr. Frank H. Mayfield, OSMA President; Paul O. Pickworth, Fair President; and Dr. R. L. Shilling.

Standing, l. to r.: Mrs. Ruth Zealley, Executive Secretary of the LCMS; Dr. I. C. Riggin; Dr. James T. Stephens, local Education Committee chairman; Dr. L. C. Meredith, LCMS Secretary-Treasurer; Edward de Chant, State Representative; Joe Hudak, Athletic Director, Amherst; Paul Landis, Ass't Commissioner, Ohio State High School Athletic Association; L. K. Butler, Director of Athletic Department, Oberlin College; Charles S. Nelson, Executive Secretary, OSMA; Dr. Denis A. Radefeld, LCMS President; Dr. Roy E. Hayes; Dr. Ben V. Myers, and Dr. H. E. McDonald.

an's Auxiliary under the direction of Mrs. G. R. Wiseman.

Consistent publicity in local newspapers during the six weeks prior to the Fair built up public expectation.

Sports Injury Conference

Another feature of the Lorain County Medical Society was its Second Annual High School Sports Injury Conference held at Hall Auditorium, Oberlin, on Wednesday, August 26, during the fair week. Athletic directors, coaches, and school authorities from all High Schools in the County and adjoining areas were among the 133 registered for the two session conference, with dinner at the Oberlin Inn.

An event of the afternoon session was Dr. D. A. Radefeld's presentation of Dr. Frank H. Mayfield, Ohio State Medical Association President, who also visited the Healthorama Tent.

Charles S. Nelson, Executive Secretary of the Ohio State Medical Association, Columbus, attended the Sports Injury Conference and visited the Healthorama.

Mr. Paul E. Landis, assistant commissioner of the Ohio High School Athletic Association, was the keynote speaker for the afternoon, followed by presentations of the responsibility of the school and of the athletic coach in the athletic programs of the schools.

Five Lorain County physicians discussed the subject, "If Injuries Occur." Covering the various areas were Peter J. Ferrato, M. D., on Injuries of the Chest; George H. Hoke, M. D., Injuries of the Head; Delbert L. Fischer, M. D., Injuries to the Extremities; R. L. Shilling, M. D., Injuries to the Face, and Roy E. Hayes, M. D., on Injury to Other Internal Organs.

The evening session was opened by Lyle K. Butler, head of the Physical Education Department of Oberlin College, followed by Ernie Biggs, trainer of Ohio State University, who gave a lecture and demonstration on Handling the Injury Problem. This feature was followed by a question and answer period.

Dr. Franklin H. Schaefer was moderator throughout this conference. The registration was almost double that of the first meeting, and plans for next year are already under way.

All who attended the Conference will receive a full report of proceedings, and the schools of the County are fully aware that Lorain County Medical Society stands ready to assist them in problems that arise.

The date of the Conference was decided upon because it coincided with the start of football

practice. If held earlier, many of the coaches and athletic directors would be away.

All arrangements were made through the School Health Committee, Chairman Dr. I. C. Riggan, and members Drs. G. J. Krupp, M. G. Fisher, R. L. Shilling and E. M. Socha. Active in the planning were School Superintendent Wm. H.



Demonstration had no small part in the High School Sports Injury Conference. Left to right are L. K. Butler, head of Athletic Department, Oberlin College; Joe Hudak, athletic director, Amherst High School; and Ernest Biggs, trainer, Ohio State University.

Jones (Avon) and Athletic Director Joe Hudak (Amherst). All expenses (with the exception of the dinner) were borne by Lorain County Medical Society.

Spirit of Civic Responsibility

Following are Dr. Mayfield's remarks at the Sports Injury Conference:

"Mr. Chairman: Today, despite the heat, I find myself in the mood of the poet who wrote 'I Feel a Song Comin' On,' for the song 'Heigh Ho, Come to the Fair' has a tone of jubilation and community pride, and it is in this spirit that citizens individually and in groups bring to the Fair their best work for their friends to admire, but also and more important, for them to profit by.

"This spirit of self-reliance and civic responsibility, in my judgment, is a keystone of America's strength, and this spirit is not new in Lorain County, for your history reveals that from the outset many individuals have recognized and accepted the responsibilities of citizenship.

"In North Carolina, my ancestral home, we know well the strength of character of the Moravians who were the original settlers here in 1787—and who could be more staunch than the New Englanders who established the first permanent settle-

Service Projects Were Features of the Healthorama



Members of the Woman's Auxiliary were mainstays in the Healthorama. Shown here are a few of the ladies who took their turns in the exhibits. Left to right: Mrs. D. L. Fischer, Mrs. G. A. Smith, Mrs. Henry P. Frankle, and Mrs. D. A. Russell interviewing visitor on right.



This exhibit on "Home Hazards" drew much public interest and is an example of the down-to-cases points brought out in the public education program.

ment here in 1810? Moreover, these people knew well that the strength of a community is based on truth and that truth arises from knowledge, for only 23 years later they established Oberlin College. This tradition of responsible citizenship is continued to the present by such persons as Congressman Baumhart and your distinguished State Senator Mosher, whom I have known and admired for a long time—and it has been a pleasure indeed to meet today your State Representatives Messrs. Brown and DeChant.

Pioneer Tradition

"The medical profession of Lorain County also continues a proud tradition of service today as exemplified in the Healthorama Tent. Your first physician, Dr. John R. Butler, came to Elyria in 1819 and was followed soon thereafter by Dr. Augustus Wolcott. As early as 1854 two Elyria physicians, Doctor L. D. Griswold and Doctor N. S. Townsend served as delegates from the Ohio State Medical Association to the American Medical Association. These physicians and many others since have accepted, in addition to their professional obligations, the responsibilities of citizenship, but nevertheless they were rugged individualists who expected of government only those things which they could not themselves achieve. The exhibit in the Healthorama Tent which I have visited at the Fair today is also the work of rugged individualists. This exhibit says in effect, 'This is good medicine. We are the custodians of your health. Come and partake.' The Lorain County Medical Society and its individual members will not have such correctable diseases as diabetes unrecognized, or such communicable and preventable diseases as polio rampant.

Courage, Not Carelessness

"Now we are gathered in the Second Annual High School Sports Injury Conference, where school authorities and athletic directors join with physicians of this county in an educational program to aid you in guiding our youth toward a way of life, as well as a way to make a living. While this might in a sense be called a safety program, it must be recognized that there cannot be, and we should not expect, a safe program. What the youth under your direction must acquire from you is physical fitness and self-reliance. They must learn that courage, not carelessness, is the opposite of cowardice. They must learn that caution and confidence are the ingredients of wisdom. They must learn that fear and falseness breed recklessness. They must learn that when the hazards of carelessness and recklessness are removed the rest of life is a calculated risk and should be lived

Four Athletic Injury Conferences Scheduled in Near Future

Jointly sponsored by the Ohio State Medical Association and the Ohio High School Athletic Association, four regional Athletic Injury Conferences are scheduled in November and December. All on Tuesdays, beginning at 1:30 p. m. the dates and places are as follows: November 17, Worthington Elementary School; November 24, Martins Ferry High School; December 1, Princeton High School, Cincinnati; December 8, Bowling Green University Student Union Building. Refer to October issue of *The Journal*, page 1404, for details.

Physicians are urged to attend the sessions in their areas. A card or letter may be addressed to the Ohio State Medical Association, 79 E. State Street, Columbus 15, Ohio, for reservation purposes.

in full. Then, though others may surpass them in any particular endeavor, they will never defeat themselves.

"Finally, let me say that it is a privileged duty to speak the greetings and good wishes of the Ohio State Medical Association to the citizens of Lorain County, to the officials of this Fair and to the participants in this conference. I wish to extend special greetings to Commissioner Landis, the Chairman of your Conference Planning Committee, to Dr. Horatio Pease, Councilor of the 11th District of the Ohio State Medical Association, to the officers and members of the Lorain County Medical Society and to its Woman's Auxiliary. I would say that the Ohio State Medical Association, representing as it does a proud and honored profession, has many stars in its crown, but none shines more brightly than the Lorain County Medical Society. The 10,000 doctors of Ohio congratulate you and pray that the high purpose of this conference will be realized."

The University of Cincinnati College of Medicine Class of 1934 at this year's reunion set up a permanent endowment fund with income to be used by the College of Medicine. An initial contribution of \$8,000 was given. The group hopes that this will establish a pattern for medical alumni giving to the college.

Dr. Austin E. Smith, president of the Pharmaceutical Manufacturers Association and former editor of *The Journal of the AMA*, has accepted appointment to the National Advisory Council of the Student AMA.

Health Commissioners Meet . . .

President Mayfield Delineates the Role of Public Health and Private Practitioner; Dr. Dwork Reports a Good Year and Praises Legislation

THE roles of public medicine and private medicine were delineated by OSMA President Frank H. Mayfield when he addressed the 40th annual Ohio Health Commissioners Conference in Columbus September 10.

Dr. Mayfield told his audience, "There are areas in the field of health which are clearly the responsibility of officers of the government such as you. There are others that by long tradition of service are just as clearly the responsibility of medical practitioners and the medical schools. There are still others in which the major responsibility is not entirely clear or is divided."

Dr. Ralph E. Dwork, State Health Commissioner, in delivering his annual report to the conference, said that Ohio has enjoyed a very good year in public health, with no serious disease outbreaks, environmental health improvements, expanded prevention in child health, augmented health education, larger hospital facilities, and important legislation by the 103rd General Assembly.

Obligation Is Prevention

Dr. Mayfield told the commissioners that the obligation of public health is prevention of disease through applied science, the responsibility of health protection in wide contacts of society. He said private practice has the responsibility of health protection in individual affliction—"the responsibility for patient care."

He outlined fields of interest for public health research, including prevention and control of infections such as staphylococcus, new methods of epidemiologic study, and the problem of carriers.

Noting that prime responsibility in the field of immunology lies with public health, Dr. Mayfield said that the school immunization law passed by the General Assembly places on public health the responsibility to see that all school children are immunized.

He added, "But it does not necessarily follow that you must immunize. On the other hand, it is equally mandatory that the medical profession not let the economic status of the patient obstruct the therapy."

Opportunities in Education

The OSMA president said that there are untold opportunities for public health education, and

called on his audience to utilize every possible source to teach the people sound hygiene and health principles.

"I am anxious that all the people of Ohio receive the highest standards of medical care, and I believe this is more likely to occur if the care of the individual remains the responsibility of his personal physician," he asserted, adding, "I feel strongly, for example, that diabetes should remain in the field of the practicing physician. The benefits of diabetes detection drives have, in my opinion, all of the defects of a one-shot effort, and, moreover, they do not relate to communicable disease."

He said an educational drive would be far more beneficial, that the drive should not be limited to diabetes "but rather to encouraging the public to submit to periodic examinations by the family physician."

Individual Search Is Waste

He praised fund raising efforts either by taxation or charity to finance research, but said that "we can waste our funds and efforts by searching individual patients for individual diseases, when a thorough examination of the patient by a physician would turn up the symptoms of any of these diseases."

Expressing conviction that a close working relationship between all groups in the health field is necessary, Dr. Mayfield suggested that work conferences between public and private medicine might be beneficial to all concerned, and to the state as a whole.

"I am not here as a petitioner for private medicine. I am here as the representative of one phase of medicine which wants to see the entire profession progress in all its elements, each functioning in the area in which it can serve best, and each cognizant of the functions and imperfections of the others," Dr. Mayfield said.

Director Reports Good Year

In his report, Dr. Dwork said that public health in Ohio enjoyed a good year on the local level as well as on the state level. He reported that four more fully qualified local health districts have brought the total to 168, that average per capita appropriation for public health in all dis-

tricts increased one cent (to \$1.38) over last year, and that total appropriations for local departments were up 2.6 per cent (to \$13,086,035).

Dr. Dwork said that the legislative session gave "a big boost to public health by increasing appropriations, by adding responsibilities, by opening opportunities. In no other recent session of the Legislature has so much, or such important, public health legislation been considered and acted upon."

Singles Out Major Acts

He singled out as important legislation the following:

Transfer of nursing and rest homes supervision to the Department of Health from the Departments of Welfare and Mental Hygiene.

Establishment of a Division of Alcoholism in the Department of Health.

Authority to control radiation sources which present public health dangers.

A law to require precautionary labeling of hazardous substances intended for household use.

The required immunization of school children against poliomyelitis, smallpox, diphtheria, pertussis and tetanus.

Compulsory immunization of dogs against rabies in quarantine areas designated by the State Director of Health.

Funds for an air pollution laboratory and research program.

Sufficient funds for expansion of Hill-Burton activities in the Hospital Facilities Division and initiation of a general hospital licensing and inspection program.

New laws to facilitate closing or conversion of tuberculosis hospitals and the financing of tuberculosis clinics.

Licensing and supervision of food vending machines.

Elimination of double licensing in food service establishments which incidentally sell baked goods or frozen desserts.

Cancer Reporting Law

A law to improve cancer reporting by making such reports confidential and relieving hospitals and physicians of the fear of damage suits for violating confidential secrets.

An act providing for combined boards of health in merged health districts where this is desirable and desired.

Provision that special health levies can be passed by a simple majority vote.

A resolution calling for a complete study by

the Legislative Service Commission of the organization and financing of general health districts and recommendations for needed revisions to be presented to the next General Assembly.

Increase in the salary of the State Director of Health from \$12,000 to \$18,000 a year, beginning with appointment for the next five-year term in November.

Oral Polio Vaccine Pending

Dr. Dwork told the health commissioners that it is important for them to consider oral polio vaccine in their immunization programs since there is a possibility that such a vaccine will be licensed by the U.S. Public Health Service in late 1960 or early 1961.

He said amendments to the Ohio Vital Statistics Law relative to filing death certificates and issuing burial permits place greater responsibility on local health departments in improving timeliness and completeness of death registration. The amendments give funeral directors some additional time in completing death certificates. Dr. Dwork expressed the hope that this will bring more accurate and complete medical certifications as to cause of death.

He pointed out that the Department's budget was increased to \$2,795,000 from \$2,086,000 last year. He said this will be adequate to carry out most of the department's programs.

New Members of OSMA

The following are the names of the new members of the Ohio State Medical Association since September 1, 1959. The list shows the county in which they are affiliated, city in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

Adams County

Caul, David, West Union
Shelton, Aultman B.,
Manchester

Cuyahoga County

Cepulis, Algimantas L.,
Cleveland
Fisher, Stuart B., Cleveland
Loewy, Erichs H., Cleveland
Oakley, Thomas K., Berea
Riley, Robert P., Cleveland
Rosen, Irving M., Cleveland
Ross, Melvin B., Cleveland
Scarpelli, Savino, Cleveland
Seymour, Robert F.,
Cleveland
Valente, Benedetto,
Cleveland

Hamilton County

DeFranco, V. James,
Cincinnati
Strandberg, Arthur F.,
Cincinnati

Franklin County

Smithwood, Robert L.,
Worthington

Lake County

Bell, Gordon K.,
Willoughby

Lawrence County

Crowe, Franklin W., Ironton

Montgomery County

French, Leo H., Jr.,
Dayton
Romer, Daniel M., Dayton
Rueger, William J., Dayton

Morrow County

Benton, Philip E.,
Mt. Gilead

Portage County

Kousaie, Frank, Kent

Workmen's Compensation Law . . .

Revised Statute Effective November 2; Detailed Analysis of Extensive Changes Made in Program by Recent Legislature Are Reviewed Here

OHIO's Workmen's Compensation Law was extensively amended during the recent regular session of the Ohio General Assembly. The revised law became effective November 2.

Following is an analysis of the amended law, based on a bulletin issued by the Ohio Manufacturers' Association.

Benefit Increase

The 66-2/3 per cent provision found in the old law was not changed, but the maximum payments were increased as shown here:

	Old	New
Temporary		
Total	\$ 40.25	\$ 49.00
Temporary		
Partial	40.25	49.00
Death	\$12,000.00	\$15,000 to \$18,000
Permanent		
Partial.....	% of \$8,050	% of 200 weeks x
Loss of		\$49.00
Members..	40.25	49.00
Old Perman-		
ent Total	25.00	40.25 (financed by new payroll tax)

The new law, which becomes effective on November 2, 1959, has no 10-year limit on temporary total payments.

The first week of benefits is paid after three instead of five weeks of disability.

The eight-year limitation from date of injury provision in death cases has been abolished.

The new law has no deduction from death benefits for payments made during life.

Certain changes in scope of coverage and in procedure were made. The most important of these follow:

Definition of Injury

Section 4123.01(C) now reads as follows:

" 'Injury' includes any injury, *whether caused by external accidental means or accidental in character and result*, received in the course of, and arising out of, the injured employee's employment." The new language is in italics.

The purpose of this change was to nullify the rule laid down by the Supreme Court in the Dripps

case. That was a case in which a man, in his work, was pulling on a wire. As the result of that pull a nerve in his arm suddenly became painful. The doctor said that the nerve was damaged by the pull. Nothing unusual occurred in the way he was pulling and the court held that the sudden damage to the nerve did not constitute an injury.

Among the elements which must still be proved to make a case compensable are the following:

1. There must be a physical or traumatic damage or harm.
2. There must be a sudden mishap occurring by chance, unexpectedly and not in the usual course of events.
3. This mishap must occur at a particular time and place.
4. Direct causal connection between the mishap and the disability must be proved.

Changes in Procedure on Appeal

Certain changes were made in the appeal sections as follows:

1. **Time of Appeal**—The claimant is given the right to appeal to court from a decision of the Regional Board without first applying to the Industrial Commission. He is also given the right to take an appeal to court from a decision of the Administrator if he applies to the Administrator for reconsideration of the decision of the Deputy. That is, the claimant can go to court whenever his claim has been turned down twice whether the two hearings are before the Deputy and the Administrator or the two hearings are before the Deputy and the Regional Board. Employers, however, must still go through the entire administrative procedure before going to court.
2. **Medical Evidence**—Either party can introduce his medical evidence by deposition instead of calling the physician to testify in person even though the physician is a resident of the county where the trial is held. The cost of the deposition is to be paid by the Industrial Commission and charged as costs in the case.
3. **Attorneys' Fees**—If the claimant prevails on appeal, his attorney's fee is included in the costs of the case, not to exceed 20 per cent of an award up to \$3,000 and 10 per cent of amounts in excess thereof, and in no event in excess of \$750.

This was in the law before 1955 but the maximum amount was \$500.

4. **Preferential Trial**—All workmen's compensation cases in the Court of Common Pleas and the Court of Appeals are preferred over most other cases and may be tried shortly after the issues are made up instead of waiting their turn on the docket.

5. **Pleadings**—When the employer appeals, the claimant must file a petition setting forth the issues in the case.

6. **Payments Pending Appeal**—The appeal section was amended to provide that an appeal from the decision of the Commission shall not stay the payment of the award *or payments of compensation for subsequent periods of total disability* during pendency of the appeal. The language in italics is new. This makes it clear that no payments are to be made for *permanent partial* disability while an appeal is pending.

If the claimant has a reasonably good chance of prevailing he can get the matter heard promptly. On the other hand, if the case is merely a nuisance case and has no merit the employer can and should insist upon the prompt disposition of the same and thus reduce the cost of court cases and eliminate the reserves which are charged against the risk for cases that are awaiting disposition by the courts.

Permanent Partial Disability Changes

In addition to the increases in benefits, the new act provides several changes in procedure in the processing of permanent partial cases.

1. **Election**—After the determination of the permanent partial disability the claimant is now required to file an election and once it is filed, it cannot be changed. The new Act gives the claimant the right to change his election "upon approval of the Industrial Commission for good cause shown." No one knows what is meant by "good cause." This is a matter that will have to be dealt with by new rules of the Commission.

2. **New Factors Affecting Award**—The Commission in determining the percentage of disability is required to consider impairment of earning capacity and vocational handicap as well as physical disability. These two elements of impairment of earning capacity and vocational handicap were in the law some years ago but were dropped because they were difficult to evaluate and required a good deal of time for the gathering of the evidence.

3. **Medical Advisory Board Abolished**—In the present Act where the evidence of disability was entirely subjective, the Commission was required to submit the question to a Medical Ad-

visory Board whose determination was binding. The Medical Advisory Board has been abolished and the requirement is eliminated from the new law.

4. **Lump Sum Payments**—The amount awarded for permanent partial disability instead of being payable prospectively, as it is under the present law, is payable from the date of last payment of compensation. This will mean that a substantial proportion of the disability award may be paid in a lump sum.

Occupational Disease Changes

Silicosis referees have been abolished and in place thereof there has been substituted a qualified medical specialist.

Radiation illness has been added to the list of occupational diseases. Claims for such illness are payable only if the death or disability occurs within eight years after the last injurious exposure. The claim must be filed within one year after disability began or within six months after diagnosis. Death claims from radiation illness must be made within six months after the death.

The statute of limitations has been extended from the present limitation of six months after disability began to two years after disability began or six months after diagnosis or six months after the claimant is informed of the diagnosis. Death claims for occupational disease may be filed within two years after the death occurred instead of six months under the present act.

The change in the statute of limitations for occupational diseases does not apply to claims for silicosis or disease of the respiratory tract or radiation illness which have their own specific limitations.

Immunity From Suit at Common Law

There was an effort in the Legislature to get the immunity of the employer from suits at common law removed in all cases where the claim was found to be non-compensable for any reason. The law was finally amended so as to remove immunity from the employer only in case the injury, occupational disease, bodily condition or death is not received or contracted in the course of or arising out of the employment. This permits an action to be brought against the employer where the injury, etc., did not arise in the course of the employment.

Changes Affecting Self-Insurers

The statute of limitations has been substantially changed as it affects self-insurers. Under the present Act, if the self-insurer had not paid com-

pensation to the claimant a written notice of the injury must be filed with the Commission within two years after the date of the injury or death.

Compensation under the present Act means payment of weekly benefits. Section 4123.01 has been amended to define compensation as including benefits and to define benefits as including:

"(1) Money, or the promise to pay money, from the state insurance fund, or from an employer who has elected and qualified under the provisions of Section 4123.35 of the Revised Code to pay directly such compensation;

"(2) The payment for or furnishing of any:

"(a) Hospital, medical, or nursing services:

"(b) Medicine, therapeutic or orthopedic device:

"(c) Other service, item, proprietary, or device occasioned by reason of injury or occupational disease."

This means that if medical treatment is given the employee by a self-insurer by reason of the injury within two years after the injury occurs the claim is open for 10 years after the medical services are rendered. The 10 years is renewed by any benefit furnished during the original 10-year period.

This means also that self-insurers will have to keep and preserve accurate records which will show whether or not any hospital, medical, nursing service or any device or treatment furnished by the employer to an employee was or was not occasioned by reason of injury or occupational disease.

Free Choice of Physician

Section 4123.651 provides that any employee who is injured shall have free choice to select such licensed physician as he may desire to have serve him as well as medical, surgical, nursing and hospital service, regardless of whether or not his employer was a self-insurer. The employer, of course, is required to pay the reasonable cost of such services. Rules relating to this matter will have to be adopted by the Industrial Commission.

Miscellaneous Changes

A wife not living with her husband is presumed to be wholly dependent in a death claim if her reason for not residing with her husband is the aggression of her husband.

The average weekly wage in occupational disease cases is determined as of the time disability due to occupational disease began.

Any period of unemployment due to any cause beyond the employee's control is eliminated from

the period used in determining the average weekly wage. Section 4123.61.

Employer must furnish employee or his dependents with copy of reports which he is required to file with the Industrial Commission.

Contractors are made liable for the unpaid premiums of subcontractors with respect to that portion of the payroll for work performed pursuant to the contract.

An award for serious facial disfigurement is made mandatory instead of permissive and the maximum is increased from \$3,750 to \$5,000.

Remedies of Industrial Commission against non-complying employers are enlarged. This is to the advantage of complying employers.

If an employer employs less than three he will come under the Act if he has made a written contract to cover his employees.

All benefit increases except death benefits will be governed by the Act in effect at the time the injury occurred except old permanent total cases which will be brought up to \$40.25 regardless of when the injury occurred. The death statute in effect at the date of death governs regardless of the date of the injury.

In general the procedural changes will be effective as to the processing of pending cases even though the injury occurred before the effective date.

Cincinnati Academy Council Adopts "Free Choice" Policy

The Council of the Cincinnati Academy of Medicine has adopted the following policy with regard to "free choice of physician":

"It shall be unethical for any member of the Academy of Medicine of Cincinnati to aid, abet, design, or render service in the operation of a medical plan which denies its beneficiaries and/or patients the right of free choice of physician. It shall also be unethical for any member of the Academy of Medicine of Cincinnati to render medical treatment and refer the responsibility for the patient's medical care to any plan, group, association, corporation, or unlicensed person in order to avoid or transfer his medical responsibility for the patient, which he assumes upon initial treatment regardless of the manner in which he, the physician, is paid for his services. Council of the Academy of Medicine of Cincinnati establishes the foregoing as the standard or custom in this locality to provide the best medical care for the patient and authorizes the Judicial Committee to make any appropriate recommendation to the Council against any member who is charged with conspiring against the patient to prevent his free choice of physician."

Hospital Relations . . .

Here Is a Report of Some of the Things that Transpired During a Recent Meeting of the American Hospital Association, of Interest to Physicians

WHAT goes on at the annual session of the American Hospital Association (the Ohio Hospital Association, also) is, and should be, of interest to members of the medical profession.

The recent meeting of the AHA was held in New York City. The proceedings were reported in the September issue of *Hospitals*, official AHA magazine. Some of the important and interesting actions and discussions as recorded in that report follow:

Hospitals and Specialists

The AHA's House adopted on its own a statement on relationships between hospitals and hospital-physician specialists. The statement reaffirmed the AHA belief that it is the right and responsibility of both hospitals and physicians to develop, on the basis of local conditions and needs, any terms, which are fair to patients and which are designed to provide high-quality care.

The new statement said, "This freedom for hospitals and physicians in the interest of patients is of fundamental importance and transcends proprietary ethical concepts and disputed legal doctrine. The AHA takes the position that good patient care is being and will continue to be provided in hospitals, both voluntary and governmental, under many forms of agreement."

The statement said that the hospital physician specialist "is expected to exercise freely and completely his medical judgment and skill . . . specialist's practice should be, from the standpoint of medical judgment, as independent as that of other staff members."

Hospitals and Public Opinion

"People have great admiration for the hospitals' technical facilities and performance, but feel the human side of hospital care is frequently given short shrift," Elmo Roper, public opinion analyst stated.

He called for "a real effort to create a warmer emotional climate in hospitals, with greater consideration and understanding accompanying the more technical aspects of treatment." Mr. Roper based his statements on a study his firm made last year for the United Hospital Fund of New York to measure people's attitudes toward various aspects of hospitals and hospital care.

Most people have only vague and inaccurate information about hospitals generally, this study

showed. "Most people are not aware that most hospitals run a chronic financial loss in the day-to-day battle against disease," he added. Public opinion is important today not only in the hospital field, but throughout our society, he said, and continued by remarking "that when human feelings and human relations are ignored, the results are detrimental to both the people whose feelings are ignored and to those who do the ignoring." Human factors are both measurable and infinitely important to any human enterprise, he said.

Prepayment Plans

The AHA, as the voice of voluntary hospitals in the U. S. must take active leadership in the preservation, extension, and improvement of the voluntary hospital system if it truly believes that the voluntary hospital system is worth preserving, according to John R. Mannix, executive vice-president of Blue Cross of Northeast Ohio.

Mr. Mannix recommended that AHA enlist the cooperation of the American Medical Association and the American Dental Association. All three associations must demonstrate cooperative leadership, and ". . . this leadership is their collective mandate if the private practice of medicine and dentistry, the voluntary hospital system and voluntary financing of these services are to be preserved, extended and improved," he said. The alternate, he argued, will be a governmental health system in the U. S.

Establishment of an "American Blue Cross" was proposed by Mr. Mannix as a means of maintaining and improving the nation's voluntary health system. He outlined features of the organization he envisions as follows:

It would be a voluntary, nation-wide organization, sponsored by hospitals, medicine and dentistry, with representation on its board from agriculture, labor and management, preferably appointed by the President. It would assure free choice of physician, dentist and hospital and would not interfere with professional relationships. The organization would be non-profit. Hospitals and the professions, through definite contractual agreements, would assume economic responsibility for benefits, and benefits would be comprehensive on a service basis.

The question of health care for the aged cannot be entirely answered by hospitals or, indeed, by other health facilities, it was agreed by a panel

discussing this subject. The panel suggested the answer must come through cooperative community planning in which health facilities are but one important factor in the search for ultimate solutions.

It was estimated that of 225 million alive in 1975, 21 million will be over 65. Because of sociological and economic factors, the percentage who live independently will decrease, and the percentage who are in homes and institutions will increase. To meet this growing problem, the need for certain changes in concepts must be recognized, and action taken.

Acute financial operating losses in most general hospitals are due to the increased care of older patients, according to Dr. Phillip D. Bonnet, administrator of Boston's Massachusetts Memorial Hospitals. "Prepayment is the best hope we have," he said, "and I think we can solve the problem through voluntary means."

In attempting to point up the development of facilities for meeting the needs of the aged, Kenneth J. Holmquist, superintendent of the Bethesda Hospital in St. Paul, Minn., noted that planning and providing such total care in cooperation with other institutions will result in the subordination of some of the hospital's independence and autonomy.

More Re Specialists

Unless the hospitals and doctors can solve the moral, ethical and financial problems involved in the hospital-hospital physician specialist relationship, the government will solve it for them as they have done in England. This was the opinion of Emanuel Hayt, counsel to the Hospital Association of New York State.

Citing the variations in laws and legal opinions now affecting this relationship in a number of states around the country, Mr. Hayt noted that "how the dollar is to be distributed" is the basis of this controversy. Involved in this problem, he said, is the matter of compensation resulting from the growth of third party payments and the various types of arrangements that these agreements now provide for.

Ray E. Brown, superintendent of the University of Chicago Clinics, said that the uniqueness of the relationship between the hospital physician specialist and the hospital and his colleagues was the basic cause of the problems that now exist. He noted that the hospital radiologist or pathologist is a physician just as is any other doctor who brings his patients into the hospital and his professional judgment is never encroached upon.

However, because he is a "doctor's doctor," because the patient does not have the freedom of choice of his services, and because the hospital

provides him with facilities and staff, there exists, in fact, a kind of monopoly which limits his freedom to set the charges to patients, he said. As a result, the hospital must use the cost mechanism in determining charges, not the price mechanism—its cost to provide the service not what the traffic will bear, he said.

Dr. F. J. L. Blasingame, executive vice-president of the American Medical Association, raised a series of questions including how the hospital administrator can satisfy the legitimate aspirations of the hospital physician specialist and, at the same time, provide competent administration, economic utilization of his resources, and the best possible service to the community, and why two similar situations cause violent upheaval in one area and hardly a ripple in another.

Growing Staff Problems

Reading a paper by Joseph J. Stahl, D. D. S., who was unable to attend, Percy T. Phillips, D. D. S., president of the American Dental Association, called for expansion of the Joint Commission on Accreditation of Hospitals to include equal representation for the dental profession.

"Complete integration must come there, at the summit," he declared, "just as we have it now in many hospitals at the local level." He denounced the classification of dentists as members of 'paramedical' professions as 'jargon to hide the truth,' charging that such semantics 'works an injustice on dentists, physicians and the public.'"

Jack Ewalt, M. D., professor of psychiatry of Harvard Medical School, discussed the expansion of psychiatric services within hospitals, warning that with this expansion comes increasing pressure from clinical psychologists for equal privileges with psychiatrists in the treatment of patients.

"The American Medical Association and the American Psychiatric Association have recognized psychotherapy as part of medical treatment to be conducted by a physician," he said, "but the field is not characterized by clear-cut cases."

Abe Rubin, D. S. C., secretary and editor, American Podiatry Society, suggested further definition of the role of the podiatrist and his surgical services in the hospital before such recognition is forced by legal and social pressures.

Increase in the number and intricacy of tests required for modern diagnosis has raised the status of the biochemist and microbiologist on the health team, said John Z. Bowers, M. D., dean and professor of medicine at the University of Wisconsin. Physicians, with their primary interest in the practice of medicine, depend more and more upon these allied disciplines. "These people must be taken into partnership with the physician in the field of diagnosis," he said.

FIRST CALL FOR ENTRIES IN

Scientific and Educational Exhibit

1960 Annual Meeting, Ohio State Medical Association
May 17, 18, 19, Cleveland, Ohio

OUTSTANDING among the features of the 1960 Annual Meeting of the Ohio State Medical Association, May 17, 18, 19, Cleveland, Ohio, will be the Scientific and Educational Exhibit. It will be in the Cleveland Public Auditorium, where all the scientific sessions of next year's meeting will be held.

The Committee on Scientific and Educational Exhibits which is in charge of this feature of the meeting consists of Dr. Charles V. Meckstroth, Columbus, Chairman; Dr. Harvey C. Knowles, Cincinnati; Dr. Robert J. Izant, Jr., Cleveland; Dr. Robert E. Zipf, Dayton; and Dr. Richard W. Booth, Columbus.

Exhibit material should fall in one of three categories: Original investigation, teaching value, or special educational value to physicians. —————→

On the opposite page will be found an application blank. If you have material suitable for an exhibit send in an application. If you know of a colleague or group of physicians who have interesting material to display suggest that they do the same. Deadline for entries is March 15, 1960.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitors as well as the costs of cards, signs, etc., which are a part of the exhibit. The Ohio State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, view boxes, current, furniture, decorations, etc., providing all items are approved in advance by the chairman of the committee. Watchman service will be provided for the exhibit.

Equipment and facilities similar to that used at AMA meetings will be used. The picture on the facing page shows the type of booth which will be provided.



The booths will be of uniform color and design. Back and side walls will be pegboard, making them extremely functional for accommodating all kinds of charts and specimens. Blue fluorescent fixtures are a part of the background and will be spaced on each exhibit to give adequate lighting. If special lighting is needed, this should be noted in application for space.

APPLICATION

For Space in the Scientific and Educational Exhibit

OHIO STATE MEDICAL ASSOCIATION, 1960 ANNUAL MEETING,
CLEVELAND PUBLIC AUDITORIUM, CLEVELAND, OHIO, MAY 17-19

1. Title of Exhibit: _____

2. Name(s) of Exhibitor(s): _____

Institution (if desired): _____

City _____

3. Do you have a built-in exhibit not requiring a back wall? _____

4. Description of Exhibit: (Attach 200 word description to this blank)

5. Exhibit will consist of the following: (Check which)

Charts and posters _____ Photographs _____ Drawings _____ X-rays _____

Specimens _____ Moulages _____ Other material _____

(Describe)

6. Booth Requirements:

Length of back wall needed? _____

Square feet needed? _____

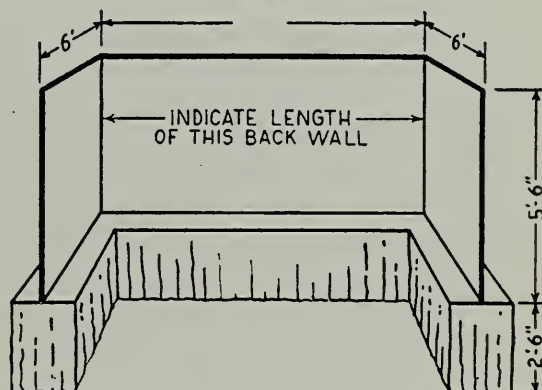
Shelf desired? (yes or no) _____

7. Transparency Cases:

Needed? (yes or no) _____

If answer "yes," give following information:

Number of transparencies to be shown and size of each _____



Booths will have a back wall and two side walls. The side walls of all booths will be six feet wide. Back wall and side walls are eight feet high. If standard shelf is used, only 5½ ft. will be available for exhibit material. For most exhibits, a back wall, eight feet long will be sufficient. With the two 6 ft. long side walls, this gives a total of 110 square feet of wall space.

(It is suggested that transparencies should be no larger than 10 by 12 inches in order to conserve space. For size of view boxes which will be supplied by the Ohio State Medical Association if requested by you and how films should be mounted, see pages 3 and 4 of folder "Regulations and Information, Scientific and Educational Exhibit, Ohio State Medical Association.")

Date _____

Signature of Applicant

Mailing Address, Street

City, Zone, State

SEND APPLICATION TO: COMMITTEE ON SCIENTIFIC AND EDUCATIONAL EXHIBIT,
OHIO STATE MEDICAL ASSOCIATION, 79 EAST STATE STREET, COLUMBUS 15, OHIO

Out of the Blue . . .

Great Need For Educational Program To Tell Public of Advantages of Insurance, Its Limitations, People's Responsibility In Making Use of It

By R. DEAN DOOLEY, M.D.

Director, Physicians' Relations Department, Ohio Medical Indemnity,
3770 N. High St., Columbus 14, Ohio

SICKNESS costs Americans 35 billion annually; 15 billion is paid out by individuals in direct expenditures, 15 billion in lost income, and the government appropriates 5 billion for health purposes. These figures are all the more impressive when you consider that 10 years ago, the cost was one-half of that amount and 20 years ago, only one-fifth as great. This fantastic increase in the expense and expanse of health care is due to the tremendous advance made in scientific medicine through research and the erection of new hospitals and the modernization of old ones to keep pace with the new advances.

Rapid progress inevitably leads to extraordinary costs related to obsolescence. New complex equipment is constantly being installed to replace the obsolete, and the demands of highly trained technicians to operate them add greatly to costs. With the technical field expanding so rapidly and the competition for technicians increasing, costs go up with the rising spiral of wages. Medicine cannot go backward—it must go forward with accelerated speed which portends even greater increases in costs.

Pay Day To Pay Day

We have an economic picture which is not bright in the light of the fact that one-fourth of our population has no savings, more than one-half has less than \$500, and only one-fourth has more than \$2000 in savings banks. To further darken the picture, one-half of the people above the age of 65, three-fourths of the farmers and two-thirds of the families with incomes less than \$2000 have no hospital or medical insurance. Prepayment insurance will pay only about one-half of the hospital bills and only 30 per cent of the professional costs.

Consumer credit relative to income after taxes has doubled in the past 10 years. Let us face the facts, Americans live from payday to payday.

Give Public the Facts

The foregoing points to the urgent need of an accelerated educational program to acquaint the

American public with the facts bearing on the expense of health care. They need to be told they enjoy the best system of health care to be found any place in the world; and they need to know that it costs money, a lot of money, to provide a health program of such superlative quality. We have done a splendid job through all informational media of alerting the public to the value of health care and they are now sold on its worth, but we are committing a great injustice by not telling the complete story including the economic aspects of the picture.

Proper Perspective

I was asked by a young surgeon at a meeting recently to suggest a fee he should charge to a patient he had treated for extensive burns. His description indicated he had spent many hours in surgery and in doing dressings. Of course, I was in no position to suggest a fee, but from his description, a sizeable fee was justified. Another physician in the audience offered the following suggestion. He recommended to the young surgeon that he call a road contractor and ask him the hourly rate charge for one of his large dirt moving machines. His logic is as follows. The cost of the equipment amounts to the approximate cost of the surgeon's education, and his time should be charged at the same rate the operator of the machine receives. Estimate the number of hours devoted in treating the patient, multiply it by the hourly rate charged for the equipment and the fee can be computed. Of course, this procedure is not recommended but it does dramatize the fact that medical charges are not so vulnerable to criticism when viewed in proper perspective.

Does the public realize the investment the physician has in his education? Does the public consider the physician is on 24-hour duty? Does the public know the harvest time of a physician's life is very short compared to other vocations and professions? It seems to me we need to tell our story, and having told it, I am very sure

the public will look upon physicians' charges in a different light.

Proper Planning

The picture is brightened by the assurance that our economy is fundamentally sound. Our productive potential is unlimited and it is not a question of being able to afford an expensive health program—rather a question of proper planning. Americans must re-orient their thinking to categorize health care a basic necessity along with food, shelter, clothes, utilities, etc., and prepare for it in the family budget with equal diligence. Prepayment insurance presents a sensible and convenient way to budget in advance for expenses incidental to illness.

There is then a great need for an educational program to inform the public of the advantages of insurance, of its limitations and of their responsibility in its use. Most of all, it is important for the public to know that compared to other commodities, they are getting a tremendous bargain in health care at present-day prices.

Construction at OSU Health Center Takes on Major Proportions

Construction and other improvements in connection with the Health Center, Ohio State University, are taking on major proportions. A report in a recent issue of *The Health Center Journal* points up some of these projects.

At University Hospital the north wing is nearing completion. The first section of this wing was completed in 1953 and has been devoted to the Cancer Clinic and cancer research. The second section was added in 1957. The third section will complete the wing as a full-scale structure of 11 stories, plus a ground level, sub-basement and mechanical equipment penthouses. The wing will add almost half again the amount of space in the original hospital building.

A two-story structure attached to the north wing and extending west from it is the new radiation therapy section. At the west extremity of this wing will be the enclosure for the betatron unit.

Major remodeling currently is being done on the first five floors of the main hospital building to improve and expand facilities.

The three-story Ohio Rehabilitation Center will be located at the southwest end of the Health Center area, backing onto King Avenue.

Plans for a north wing, three-fourths the size of the present building will be developed for the Columbus Psychiatric Institute and Hospital within the next two years.

Another project in progress is construction of

an underground explosion-proof room for storage of flammables and explosives. It is located between the psychiatric and tuberculosis hospitals.

The College of Dentistry has just extended its building east to Neil Avenue, adding more than half again the amount of space previously available.

Work is well under way on the two-story Health Center Research Laboratories. It is being constructed north of University Hospital.

Certain areas of expansion at the OSU Research Center, located west of the Olentangy River on Kinnear Road, affect investigations done in the College of Medicine. A nuclear teaching reactor is expected to be completed soon. The Research Services Laboratory of the Institute of Nutrition and Food Technology is being activated. The Institute for Research in Vision is developing a section there.

Boost Facilities for Children by Building Program in Columbus

With construction well advanced on part of the project, Children's Hospital of Columbus is scheduled to become the nucleus of the Children's Medical Center. An area bounded on the north by Donaldson Street, on the south by Livingston Avenue, on the west by Parsons Avenue and on the east by Eighteenth Street, is gradually being cleared of dwellings and business establishments to make way for the various building units.

A recent issue of *The Ohio State University Health Center Journal* lists the following projects:

A 166-bed addition which will nearly double the capacity of Children's Hospital, bringing it to 400 beds, is well under way and should be completed by late spring.

A three-floor extension of Timken Hall will double the capacity of the student nurses' dormitory, allowing for 170 girls. This unit is scheduled for use by early spring.

A new Nurse Education Building, east of Timken Hall is nearing completion.

Construction on a three-floor research building is scheduled to start soon. The unit will house research being done by the Children's Hospital Investigative Laboratories Division.

The Children's Mental Health Center is functioning in temporary quarters converted from old houses. Plans are nearing completion for a new building for this purpose.

A Crippled Children's Treatment Center is planned by the Franklin County Society for Crippled Children. Construction should begin early on the first phase of a unit which can be added to in the future.

In Memoriam . . .

C. L. Baskin, M. D., Raleigh, N. C.; University of Michigan Medical School, 1912; aged 78; died September 19; former member of the Ohio State Medical Association. A veteran of World War I, Dr. Baskin moved to Akron in 1920 after doing residency work in Detroit. He retired in 1954 and moved to North Carolina. Affiliations included membership in the Masonic Lodge and the Presbyterian Church. Surviving are his widow, three sisters and three brothers.

Lloyd H. Cox, M. D., Dayton; Howard University College of Medicine, 1904; aged 79; died September 8; member of the Ohio State Medical Association and the American Medical Association. A practicing physician in Dayton for some 54 years, Dr. Cox was a member of the Cincinnati Ophthalmology Club. Active in civic and fraternal affairs, he was for many years associated with Red Cross and YMCA work. Surviving are his widow, a daughter and two sons.

Owen C. Davison, M. D., Bethel; Miami Medical College, Cincinnati, 1904; aged 78; died September 19; member of the Ohio State Medical Association and the American Medical Association. A native of the Bethel area, Dr. Davison served virtually all of his professional career there. Five years ago the community joined with the profession in honoring him on completion of 50 years of practice. Surviving are his widow, two sons and a daughter.

Charles Alfred Dixon, M. D., Akron; Cleveland Medical College, Homeopathic, 1893; aged 89; died October 1. Dr. Dixon began his practice in Akron shortly after completing his medical training. During World War I he served in the Army Medical Corps in the grade of captain. A son survives.

Andrew J. Extejt, M. D., Toledo; St. Louis University School of Medicine, 1934; aged 52; died July 10; member of the Ohio State Medical Association and the American Medical Association.

John P. Fairchild, M. D., Freeport; Ohio State University College of Homeopathic Medicine, Columbus, 1919; aged 69; died September 23; member of the Ohio State Medical Association and the American Medical Association. Dr. Fairchild began practice in Cambridge, moved to Antrim and in 1938 moved to Freeport. He was a member of the Masonic Lodge and the Presbyterian Church. Surviving are his widow, a son and a daughter.

Samuel J. Feingold, M. D., Canton; University of Pittsburgh School of Medicine, 1914; aged 68; died September 27; member of the Ohio State Medical Association and the American Medical Association. Dr. Feingold began practice in Canton in 1915, served in the Army Medical Corps during World War I, and later took graduate work in Europe, returning to Canton each time to continue his practice. He was a member of Temple Israel and B'nai B'rith. Surviving are his widow, three sisters and two brothers, one of whom is Dr. Ben F. Feingold, of San Francisco.

Curtiss M. Ginn, M. D., Dayton; Cleveland University of Medicine and Surgery, 1895; aged 87, died September 10; former member of the Ohio State Medical Association and Fellow of the American College of Surgeons. Dr. Ginn took his internship at Miami Valley Hospital and continued his practice there until his retirement in 1945. Long a member of the Montgomery County Medical Society, one of his achievements was compiling a history of that organization. Survivors include his widow and a son.

Ralph H. Jamison, M. D., Warren; Duke University School of Medicine, 1946; aged 36; died October 4; member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Surgery. An early resident of Warren, Dr. Jamison returned there to practice after doing residency work in Cleveland hospitals. He had been in practice in Warren for five years. Survivors include his widow, two sons, a daughter, his parents and a sister.

George W. Keil, Sr., M. D., Blacklick; Franklin County; Columbia University College of Physicians & Surgeons, 1912; aged 72; died September 21; former member of the Ohio State Medical Association. Retired from practice for several years, Dr. Keil formerly served as physician at the Ohio Penitentiary in Columbus for about 15 years. He is survived by a son and a sister.

William A. Knowlton, M. D., Cleveland; University of Wooster, Medical Department, Cleveland, 1895; aged 87; died September 19. Dr. Knowlton practiced for some 65 years, mostly in the southeast area of Greater Cleveland. Surviving are a son and a daughter.

Eugene F. Kornreich, M. D., Chagrin Falls; Western Reserve University School of Medicine, 1924; aged 64; died September 21; member of the Ohio State Medical Association and the American Medical Association. Dr. Kornreich practiced

medicine in Cleveland for 30 years. He moved to Chagrin Falls about three years ago after retiring because of illness. A member of the Masonic Lodge, he is survived by his widow, two sons, his mother and a sister.

John S. Kovach, M.D., Cleveland; St. Louis University School of Medicine, 1930; aged 53; died September 21; member of the Ohio State Medical Association and the American Medical Association. A practicing physician in Cleveland for a number of years, Dr. Kovach was a veteran of World War II, having served three years in the Coast Guard. Surviving are his widow, a son, his father and a brother, Dr. Ralph J. Kovach, also of Cleveland.

William J. Ledwin, M.D., Cincinnati; Eclectic Medical College, Cincinnati, 1921; aged 83; died September 28. A former Cincinnati practicing physician and assistant health commissioner, Dr. Ledwin retired in 1949 after serving with the local health department for 26 years. Affiliations included membership in the Knights of Columbus. Five sons and a daughter survive.

Walter I. LeFevre, M.D., Cleveland Heights; Bellevue Hospital Medical College, New York, 1897; aged 85; died September 23; former member of the Ohio State Medical Association; diplomate of the American Board of Radiology. A practicing physician in Cleveland until his retirement in 1948, Dr. LeFevre was a pioneer in the field of radiology. He was a member of several professional organizations and wrote extensively on subjects relating to his specialty field. Local affiliations included membership in the Rotary Club. Survivors include his widow and a son, Dr. Fay A. LeFevre, also of Cleveland.

Dominic L. LoPorto, M.D., Albuquerque, New Mexico; St. Louis University School of Medicine, 1930; aged 54; died September 28; former member of the Ohio State Medical Association. Dr. LoPorto practiced for about 25 years in Garfield Heights in the Greater Cleveland area. He moved to New Mexico three years ago. Survivors include two brothers and a sister.

Ignatius W. Matuska, M.D., Cleveland; Western Reserve University School of Medicine, 1914; aged 71; died October 2; former member of the Ohio State Medical Association and the American Medical Association. A native of Cleveland, Dr. Matuska practiced there for 45 years. He was a member of the Catholic Church. Survivors include a son, a daughter and four brothers.

Lee W. McGuire, Batavia; Medical College of Ohio, Cincinnati, 1906; aged 76; died October 1.

A native of Clermont County where he was living in retirement, Dr. McGuire was chief of medical services at Malden General Hospital near Boston for 25 years and before that was in the Navy Medical Corps. His widow and three sons survive.

James C. Medley, M.D., Youngstown; University of Pittsburgh School of Medicine, 1953; aged 34; died September 29; member of the Ohio State Medical Association and the American Medical Association. Dr. Medley was in practice in Austintown, west of Youngstown for four years after doing residency work in Youngstown. He served in the Marine Medical Corps during World War II. Surviving are his parents and a brother.

George H. Reinhardt, M.D., Cleveland; College of Physicians and Surgeons of Baltimore, 1904; aged 79; died October 4; former member of the Ohio State Medical Association. Dr. Reinhardt retired in 1948 after practicing for about 23 years in Cleveland. He was a veteran of World War I, having served with the Army Medical Corps. A son survives.

Elmer Galen Rex, M.D., McConnelsville; Medical College of Virginia, 1928; aged 58; died September 8; member of the Ohio State Medical Association and the American Medical Association. A native of Morgan County, where his father, the late Dr. E. G. Rex, practiced before him, Dr. Rex served that area for many years. Ill health forced his retirement some time ago. Local affiliations included membership in the Masonic Lodge. His widow and a son survive.

Frank A. Shuffleton, M.D., St. Marys; Hahnemann Medical College and Hospital, Chicago, 1900; aged 82; died October 7; former member of the Ohio State Medical Association. A practicing physician for many years in St. Marys, Dr. Shuffleton died in Columbia, S. C., where he was visiting a daughter.

Earlin J. Simms, M.D., Columbus; Ohio State University College of Medicine, 1911; aged 72; died October 8; member of the Ohio State Medical Association and the American Medical Association. Dr. Simms served all of his professional career in Columbus. Affiliations included memberships in the Elks Lodge and the Methodist Church. He is survived by his widow and a daughter.

Russell H. Williams, M.D., Ft. Lauderdale, Florida; Ohio State University College of Medicine, 1925; aged 67; died September 14; member of the Ohio State Medical Association and the American Medical Association. A former grad-

uate of Denison University, Dr. Williams returned to Granville to practice in the middle 1920's. He was health officer for the University for more than 25 years. A veteran of World War I, he was a member of the Masonic Lodge, the Knights of Pythias and the Rotary Club. Surviving are his widow, three daughters, a son and a brother.

Richard H. Wilson, M.D., Martins Ferry; Barnes Medical College, St. Louis, 1898; aged 84; died September 11; member of the Ohio State Medical Association, the American Medical Association, the International College of Surgeons and Fellow of the American College of Surgeons. A practicing physician for more than 60 years in the area, Dr. Wilson was associated with numerous community activities. He founded the Martins Ferry City Hospital and contributed substantially to its upkeep and growth. He was active in numerous organizations including the Kiwanis Club, the Board of Trade, Knights of Pythias, Junior Order of American Mechanics, several Masonic bodies and the Presbyterian Church. He served as chairman of fund drives for such organizations as the Boy Scouts and the establishment of the local Lincoln Center. Surviving are his widow, a grandson, a sister and two brothers.

Paul H. Zinkhan, M.D., Ravenna; Georgetown University School of Medicine, 1912; aged 74; died September 4; member of the Ohio State Medical Association and the American Medical Association. Dr. Zinkhan went to Ravenna after World War I, during which he served overseas. In addition to his professional activities, he was associated with many local organizations, among them the local Board of Education, several Masonic bodies, the Elks Lodge, the American Legion, the Episcopal Church. He retired several years ago, but later became physician for the Portage County Home for the Aged. His widow survives.

Industrial Fellowships

The University of Cincinnati's Institute of Industrial Health is offering graduate fellowships in Industrial Medicine. The Institute, which is in the College of Medicine, provides professional training for graduates of approved medical schools who have completed at least one year of internship.

Requests for additional information should be addressed to: Secretary, Institute of Industrial Health, College of Medicine, Eden and Bethesda Avenues, Cincinnati 19, Ohio.

The Institute also offers graduate training for professional personnel other than physicians in the field of environmental hygiene.

DALLAS in DECEMBER 1-4

American Medical
Association



13th clinical meeting

PROGRAM HIGHLIGHTS

The Role of Medicine in the Space Age—Hubertus Strughold, Professor and Advisor for Research, School of Aviation Medicine, Randolph AFB

Indications for Hysterectomy—Willis H. Jondahl, Harlingen, Texas—Lecture

Rheumatoid Arthritis—W. Paul Holbrook, Tucson, Ariz. Panel Moderator

Colloidal Isotopes and Leukemia—Joseph M. Hill, Dallas—Lecture

Treatment of Diabetes—Randall G. Sprague, Rochester, Minn.—Panel Moderator

Infectious Diseases in Children—Harris D. Riley, Jr., Oklahoma City—Panel Moderator

Tranquilizers in Medical Practice—Stewart Wolf, Oklahoma City—Lecture

Surgical Approaches to Parkinson's Disease—William W. McKinney, Fort Worth—Lecture

Congestive Heart Failure—James V. Warren, Galveston—Panel Moderator

Peptic Ulcer in Rheumatoid Arthritis—Lloyd G. Bartholomew, Rochester, Minn.—Lecture

Immunization and its Future—Blair E. Batson, Jackson, Miss.—Lecture

Children's Eyes—Tullio O. Coston, Oklahoma City—Lecture

Obstetrical Emergencies—Willis E. Brown, Little Rock, Ark.—Panel Moderator

Hernia Repair—Francis C. Usher, Houston—Lecture

Premarital and Marital Counseling—Oren R. Depp, New Orleans—Panel Moderator

Anticoagulants and Choice of Drugs—James W. Culbertson, Memphis, Tenn.—Lecture

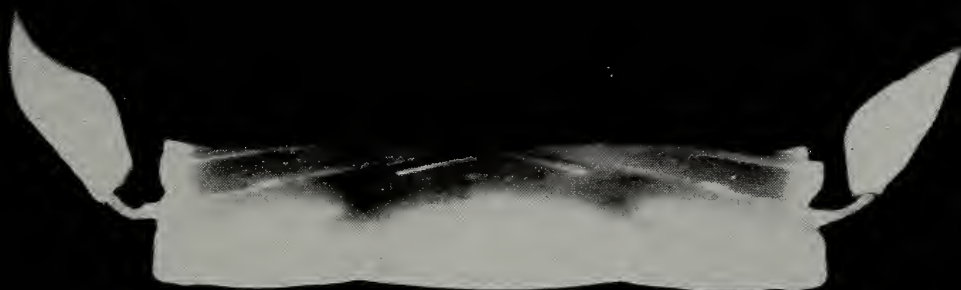
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Pro-Banthine with Dartal contains two agents required for such dual therapy: Pro-Banthine to control and curtail the flare-ups of spasm, excess acidity and excess motility,

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* * *

Eye Care and Prepayment Plans. Booklet is a report to the medical profession and covers development of medical and retirement plans, application of service plans to eye care, and an ophthalmological service plan. Wright National Medical Foundation for Eye Care, 250 West 57th Street, New York 19, N.Y.

Identification of School Children Requiring Eye Care. Covers nature and objective of a school health program and operation of an eye health program, testing, instruments and equipment, effectiveness and evaluation of program, school physician-parent relations, and follow-up. Write National Medical Foundation for Eye Care, 250 West 57th Street, New York 19, N.Y.

When Our Parents Get Old. Booklet discusses many aspects of this delicate and often difficult problem. Primarily concerns a three-generation household. Useful for individual counseling, study groups and program planning. Write Health and Welfare Department, Metropolitan Life Insurance Company, 1 Madison Avenue, New York 10, New York.

How to Obtain Birth Certificates. Shows where to apply for and cost of obtaining birth certificates in each state, along with citations in statutory provisions for delayed registration. (10 cents) Write Superintendent of Documents, Government Printing Office, Washington 25, D. C.

The Forand Bill and What You Should Know About It. This question and answer leaflet highlights basic implications and faults of the Forand Bill. Write AMA, 535 North Dearborn Street, Chicago 10, Illinois.

Heroic Exploits of American Fighting Men. Fourteen full-color reproductions of paintings depicting American fighting courage in every war from the Revolution to Korea. (\$2.50 per set) Write Superintendent of Documents, Government Printing Office, Washington 25, D. C.

The Older Person in the Home. Outlines basic principles and problems when three generations live under the same roof. (20 cents) Write Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C.

Immunization Information for International Travel. Booklet designed for travelers going abroad and for physicians and health departments. Gives current details on immunization requirements for entry in U. S. and 200 other countries. (30 cents) Write Superintendent of Documents, Government Printing Office, Washington 25, D. C.

Prevention of Blindness. Fourteen leaflets on eye care and prevention of blindness written by professional men for lay readers. Some are revisions of popular leaflets; some are new. Write Prevention of Blindness Department, Philadelphia Association for the Blind, Inc., 100 East Price Street, Philadelphia 44, Pa.

Cancer Prevention through Colpophotography. Book deals with study and research of the subject, and means of recording observation through scientific photography. Contains six actual studies in form of pictured illustrations. Write Scientific Department, Exakta Camera Company, 705 Bronxville Road, Bronxville, New York.

Articles of Association for Unincorporated Associations. Helpful suggestions, including sample articles of association, for physicians planning to organize an unincorporated association for medical practice. Write Law Division, AMA, 535 North Dearborn, Chicago 10.

Profile of the Health Insurance Public. Summary of nationwide study of pattern of health insurance coverage and American public's regard for health insurance as a means of financing health care costs. Write Health Insurance Institute, 488 Madison Avenue, New York 22, N.Y.

Medicolegal Forms with Legal Analysis. Survey of malpractice insurance policies with sample consent forms for carrying out surgical procedures. Write Law Division, AMA, 535 North Dearborn Street, Chicago 10.

Home Care of the Child with Rheumatic Fever. Guide prepared especially for parents of children who have or are recovering from rheumatic fever and for whom hospital care is not advised or not available. Write Ohio State Heart Association, 131 East State Street, Columbus 15, Ohio.

Group Methods in Therapy. Discusses in detail applications of group methods to wider range of persons with ailments, physical, chronic and mental. (25 cents) Write Public Affairs Pamphlets, 22 East 38th Street, New York 16, New York.

Northwestern Ohio Medical Association Elects Officers at Meeting

More than 125 physicians from 18 counties attended the meeting of the Northwestern Ohio Medical Association in Findlay on October 7. The organization is composed of physicians from the Third and Fourth Councilor Districts.

Officers were elected as follows: President, Dr. Francis M. Lenhart, of Defiance; vice-president, Dr. David L. Steiner, of Lima; secretary, Dr. Clovis Altmaier, of Marion; treasurer, Dr. John C. Smithson, of Findlay.

The group voted to continue its meetings and to hold its 1960 session in Defiance. Exhibited at the meeting was the 90-year-old minutes book of the Association, which has been kept from the time the initial meeting was held shortly after the Civil War. The Association voted to have the volume rebound and preserved properly.

The Findlay Republican Courier devoted nearly two columns to a report of the meeting. A team from Ohio State University College of Medicine presented the program with Dean Charles A. Doan giving the luncheon address on the subject of medical education.

Do You Know? . . .

Dr. Harold G. Reineke, Cincinnati, was named president-elect of the American Roentgen Ray Society at its 60th annual convention in Cincinnati.

* * *

Dr. R. Dean Dooley, formerly a practicing physician in Dayton and now director of professional relations for the Ohio Medical Indemnity in Columbus; and Miss Elizabeth Lyman, women's editor of the *Dayton Daily News*, were honored at the 19th annual meeting of the Social Hygiene Association of Dayton.

* * *

Dr. John Holmes Dingle, Cleveland, was given the 1959 Albert Lasker Award for outstanding achievement in public health.

* * *

Dr. Charles C. Higgins, Cleveland, was named first vice-president-elect at the conclusion of the American College of Surgeons meeting in Atlantic City.

* * *

George H. Saville, OSMA Director of Public Relations, participated in a panel on "Ideas on Public Relations," at the 10th Annual Meeting of the American Nursing Home Association, October 7, in Chicago.

Annual Clinical Conference

CHICAGO MEDICAL SOCIETY

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Daily Half-Hour Lectures by Outstanding Teachers and Speakers on subjects of interest to both general practitioner and specialist.

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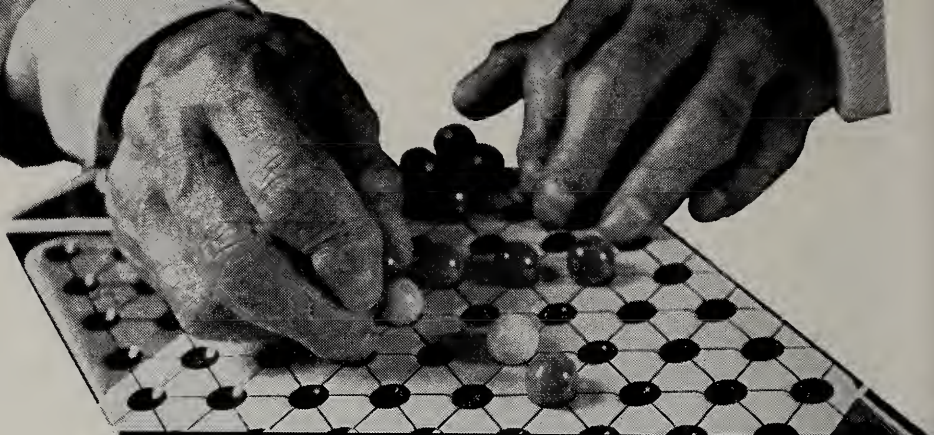
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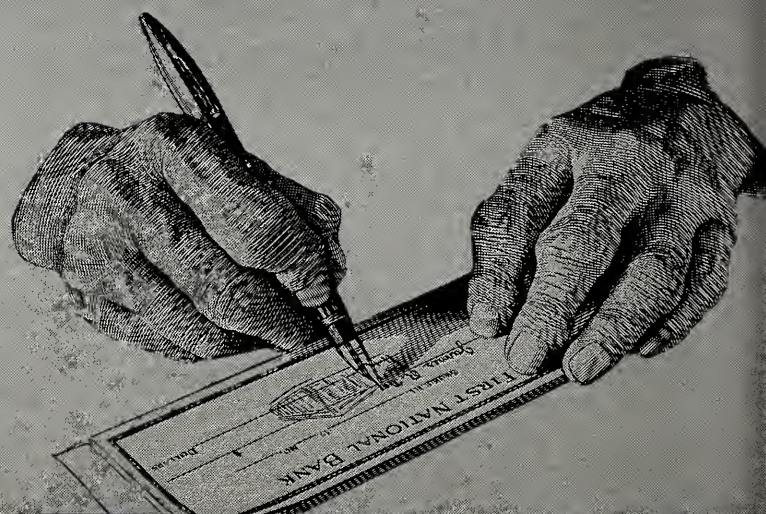
The Chicago Medical Society Annual Clinical Conference should be a MUST on the calendar of every physician. Plan now to attend and make your reservation at the Palmer House.

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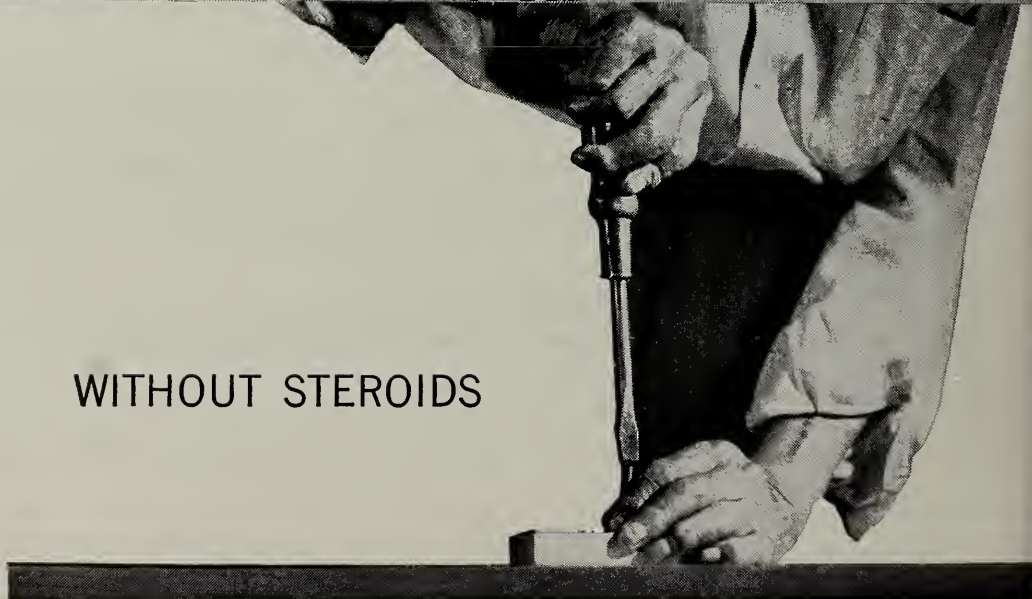


In every arthritic state.

WITHOUT STEROIDS



WITHOUT STEROIDS



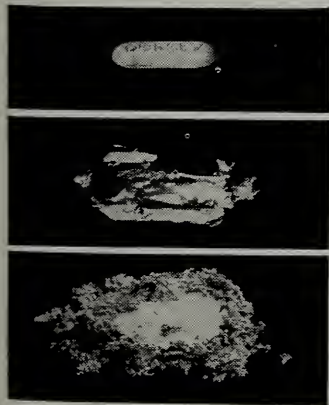
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Sound, conservative therapy with salicylates has been consistently reaffirmed as basic, long-term maintenance therapy in the arthritides.

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Buffered Pabirin is formulated to provide high and sustained salicylate blood levels. Each tablet consists of an outer layer containing a buffer (aluminum hydroxide), para-aminobenzoic acid, and ascorbic acid; a core of acetylsalicylic acid.

In the stomach, the outer layer quickly releases the buffer, which protects against nausea, dyspepsia and other gastrointestinal symptoms so frequently encountered with salicylates alone. The core of Buffered Pabirin then disintegrates rapidly, permitting rapid absorption of the acetylsalicylic acid for faster pain relief.



Photographs show 2-stage
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Dried aluminum hydroxide gel.....100 mg.

All Buffered Pabirin is sodium- and potassium-free.

Dosage: Two or three tablets
3 or 4 times daily.

References: 1. Hart, D.; Bagnall, A. W.; Bunim, J. J., and Polley, F. H.: Ninth International Congress on Rheumatic Diseases, Toronto, Ont. (June 25) 1957. 2. Report of Joint Committee, Medical Research Council & Nuffield Foundation, Treatment of Rheumatoid Arthritis, British Medical Journal (April 13) 1957. 3. Friend, D. G.: New England J. Med. 257:278 (Aug.) 1957.

Buffered **Pabirin[®]** *Tablets*

Ohio Farm Bureau News Discusses S. B. 461

In its October issue the *Ohio Farm Bureau News* commented on Amended Sub. S. B. 461, an enabling act for medical care plans, passed by the recent General Assembly. It was sponsored by the Farm Bureau, CIO-AFL and United Mine Workers. A complete review of the act appeared in the August issue of the *Ohio State Medical Journal*. The following excerpts from the *Ohio Farm Bureau News* on the act will be of interest to Ohio physicians:

"The Ohio Farm Bureau Federation was one of the leaders in securing the passage of Sub. S. B. 461 in the recently-adjourned Ohio General Assembly.

"The bill called the 'Community Health Bill' also had wide support from many areas of the state and from numerous groups * * *

"The bill is enabling legislation which will permit the people of Ohio to organize and develop additional methods for prepaying the cost of medical care.

"Most Ohio Farm Bureau members have health insurance.

"Existing health insurance sold in Ohio agrees to pay the policyholder an agreed amount of money when certain illness strikes. To many Ohio farm families this health insurance has proved its value many times. Existing coverages handle only about one-third of a family's expense, however, and usually do not provide coverage for visits to the doctor's office or preventive health services. Much of the serious illness might be avoided if the patient had access to a doctor early so that disease could be caught before it became acute.

"Perhaps the most important reason why the Ohio Farm Bureau supported this bill was the fact that it offered a means whereby our rural families could attract doctors to areas that are now without physicians or do not have adequate health personnel in the area.

"Sub. S. B. 461, now Section 1738 of the revised Ohio Code, will permit the formation of medical care cooperatives. The co-ops can be organized and developed by the people in the community to be served. In cooperation with the doctors in the area, or those attracted to the area, a medical care program can be worked out to specifically meet the needs of the local people. * * *

"If there are no doctors in the area the corporation will have to recruit doctors. This job will be easier because the physician will be assured of a practice and an income because the corporation will have organized the people's payment for medical care.

"The corporation then agrees to pay the doctor

so much per month for providing the services for which the members have subscribed. Usually there is no extra charge beyond the monthly subscription, although this is a matter for the local community to determine.

"It will require about 300 families to support one doctor full time, if more people subscribe perhaps specialist care, on a part-time basis, can be arranged from a nearby city. In other words, the number of people that subscribe and the amount of money they are willing to pay each month will determine how much medical care can be offered.

"Such programs have been effective in many other areas of the United States in both rural and urban communities. For an agreed-upon monthly fee the subscriber is assured of certain medical services rendered by the physicians co-operating with the corporation."

Fort Steuben Academy

"Unusual Manifestations of the Arthritides," was the subject discussed at the October 13 dinner meeting of the Fort Steuben Academy of Medicine in Steubenville. Speakers were Dr. Henry K. Taylor, New York, and Dr. Gilbert H. Alexander, director of radiology, St. Francis Hospital, Pittsburgh.



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Supplied: Tiny 10 mg., 25 mg., and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

References: 1. Farah, L.: *Internat. Rec. Med.* 169:379 (June) 1956. 2. Smigel, J. O., et al.: *J. Am. Geriatrics Soc.* 7:61 (Jan.) 1959. 3. Feinberg, A. R., et al.: *J. Allergy* 29:358 (July) 1958. 4. Eisenberg, B. C.: *J.A.M.A.* 169:14 (Jan. 3) 1959. 5. Maryssael, L.: *Bruxelles-méd.* 33:141 (Jan. 26) 1958. 6. Pfleger, R.: *Med. Klin.* 53:1030 (June 5) 1958. 7. Over 200 laboratory and clinical papers from 14 countries.

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Warning About Residents Issued By Selective Service

Following is the text of a directive issued recently by National Selective Service Headquarters to all state directors and which should be heeded by those in charge of residency training programs:

It has come to the attention of National Selective Service Headquarters that administrators of many hospitals and medical schools are accepting physicians for residency training without regard to their liability for military service. It is requested that State Directors of Selective Service inform hospitals and medical schools in their States (1) that local boards of the Selective Service System have been informed that a physician should not be placed in Class II-A to complete residency training unless in the opinion of the local board his services are absolutely essential to the operation of the hospital or he is a participant in a residency training program of the Armed Forces or Public Health Service, and (2) that all other physicians who are not veterans may be ordered to report for induction, if a call for physicians is placed upon the Selective Service System during their residency training.

Ohio Academy of General Practice Elects Officers for Year

The Ohio Academy of General Practice installed Dr. Lewis W. Cellio, Columbus, as president for the year during its ninth annual Scientific Assembly in Columbus, September 16 and 17, and named Dr. Roger A. Peatee, Bowling Green, as president-elect.

Other officers elected were Dr. Raymond M. Kahn, Dayton, treasurer; Dr. Landon L. Palmer, Toledo, speaker of the House; and Dr. Albert D. Weyman, Cincinnati, vice-speaker.

Three new District directors were elected as follows: District 1, Dr. Eugene P. Fromm, Cincinnati; District 3, Dr. Edward B. Young, Lima; District 7, Dr. A. John Antalis, Powhatan Point.

Registration for the meeting was 1014, of which 601 were physicians.

Headquarters office of the Academy is at 1500 West Third Avenue, Columbus 12. Robert Wilson is executive secretary.

Help Fight TB



Use Christmas Seals

Cook County Graduate School of Medicine INTENSIVE POSTGRADUATE COURSES

STARTING DATES — FALL-WINTER

SURGERY—Surgical Technic, two weeks, Nov. 30, Feb. 1, 1960. Surgery of the Colon & Rectum, one week, Nov. 30. Gallbladder Surgery, three days, Apr., 1960. Surgery of Hernia, three days, Apr., 1960. General Surgery, two weeks, Dec. 7. Board of Surgery Review Course, Part II, two weeks, Spring, 1960. Blood Vessel Surgery, one week, Nov. 30.

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, Feb., 1960. Vaginal Approach to Pelvic Surgery, one week, Nov. 16. General & Surgical Obstetrics, two weeks, Nov. 2.

MEDICINE—Diseases of the Chest, one week, Nov. 2. Gastroscopy & Gastroenterology, two weeks, Spring, 1960. Board Review Courses, Spring, 1960.

UROLOGY—Two-Week Intensive Course, Apr., 1960. Ten-Day Practical Course in Cystoscopy, by appointment.

RADIOLOGY—Diagnostic Radiology, two weeks, Nov. 30 and Spring 1960.

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


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NABCON concentrates in one tasty teaspoonful all the active components of 35 brewer's yeast tablets.

Now you can give your patients the full range of B complex *natural* vitamins as presented by brewer's yeast . . .

Leading authorities always have recognized the value of brewer's yeast, but the necessity of giving a patient 30 to 40 large tablets a day has limited the usefulness of this valuable vitamin source. Now—*one* teaspoonful of NABCON a day will give the same results—results often significantly superior to synthetic B complex mixture.

Whether the patient is 3 years or 80 years old, for gratifying clinical response and willing patient co-operation, prescribe NABCON in 4 oz. bottles—a month's supply.

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Activities of County Societies . . .

First District

(COUNCILOR: CHARLES W. HOYT, M. D.,
CINCINNATI)

ADAMS

A business meeting and program of the Adams County Medical Society was held in the office of the Adams County Department of Health with luncheon following in the Hospital dining room. Dr. Harry C. Shirkey, Cincinnati, discussed the subject, "Poisonings in Children."

CLINTON

Dr. Harvey Knowles, Cincinnati, spoke on diabetes at the luncheon meeting of the Clinton County Medical Society on September 1 in Wilmington.

HAMILTON

The October 20 meeting of the Academy of Medicine of Cincinnati was a joint session with the Cincinnati Society of Internal Medicine. The subject, "Resistant Infections," was discussed by Dr. Ivan L. Bennett, Jr., pathologist-in-chief of the Johns Hopkins Hospital, Baltimore, Md.

The October schedule included also a number of meetings of local specialty societies.

Second District

(COUNCILOR: RAY M. TURNER, M. D., SPRINGFIELD)

CLARK

The proposed Springfield School District bond issue and operating levy to appear on the November ballot were endorsed by the Clark County Medical Society at its September dinner meeting in Hotel Shawnee.

Dr. I. H. Boesel, a practicing physician in Springfield since 1924, was presented a 50-year pin and award for his 50 years as a physician. Dr.

Boesel was graduated from the University of Michigan Medical School in 1909, receiving his license to practice the same year.

Principal speaker for the evening was Dr. Joseph F. Tomashefski, director of the cardio-pulmonary laboratory at the Ohio Tuberculosis Hospital in Columbus. Dr. Tomashefski discussed "Pulmonary Function Testing." Society President Dr. William P. Montanus presided at the meeting. —*Springfield News*.

GREENE

September meeting of the Greene County Medical Society was held the morning of the 10th in the Greene Memorial Hospital Lounge, with Dr. Paul C. Vernier presiding.

Dr. Benjamin F. Lee was appointed secretary to fill the vacancy created when Dr. Quentin Erd of Jamestown moved out of the state. Mrs. Richard Downing, newly appointed executive secretary was introduced to the group.

Dr. Meinhard Robinow presented Dr. Frederick MacCabe Jr., director of the new Greene County Child Guidance Center, who spoke about "The Scope and Function of the Greene County Child Guidance Center." He explained the problems of the troubled child as they affect the home, school and community, and their relations between the family doctor and the psychiatrist. The Child Guidance Center is located at 536 W. Maret St.

Coffee was served by the Ladies' Auxiliary with Mrs. J. R. Schauer and Mrs. T. H. Winans acting as hostesses. —*Xenia Gazette*.

MIAMI

Dr. Charles Gerson, Dayton, was guest speaker at the October 2 meeting of the Miami County Medical Society at the Piqua Memorial Hospital.



MARY POGUE SCHOOL, INC.

Founded 1903. Complete facilities for training retarded and epileptic children educationally and socially. Pupils per teacher strictly limited. Excellent educational, physical and occupational therapy programs.

Varied group activities under competent direction on our spacious grounds of 28 acres. Selected movies.

Separate buildings for boys and girls, each with round-the-clock supervision of skilled personnel. Total enrollment 90.

G. H. Marquardt, M. D.
Medical Director

Barclay J. MacGregor
Registrar

29 GENEVA ROAD, WHEATON, ILLINOIS
(Near Chicago)

His topic was, "Untoward Effects of Drugs and Procedures Used in Heart Disease."

MONTGOMERY

The Montgomery County Medical Society sponsored its third annual Athletic Injury Conference on September 1 at the Van Cleve Hotel in Dayton. Chairman of the Conference Committee was Dr. E. E. Archdeacon, and principal speaker was Dr. Robert Murphy, OSU Football Team physician.

Third District

(COUNCILOR: FLOYD M. ELLIOTT, M. D., ADA)

ALLEN

Dr. Arthur T. Evans, professor of urology at the University of Cincinnati College of Medicine, was guest speaker at the dinner meeting of the Lima and Allen County Academy of Medicine on September 15 in the Shawnee Country Club. His subject was "Abdominal Aortography."

Fourth District

(COUNCILOR: W. W. GREEN, M. D., TOLEDO)

LUCAS

The October schedule of the Academy of Medicine of Toledo and Lucas County contained the following features:

October 2—General Section, "Voluntary Prepayment Insurance, Its Scope and Impact on the Future Course of American Medicine," Dr. R. Dean Dooley, professional relations director, Ohio Medical Indemnity.

October 8—General Practice Section, "Office Proctology," Dr. W. W. Green and Dr. W. A. Blank, Toledo.

October 16—Medical Section, "Newer Developments in Diabetes," Dr. Fred W. Whitehouse, Detroit.

October 22 and 23—Surgical Section and Postgraduate Lecture Series, "Metabolism in Surgery and Acute Disease," Dr. Francis D. Moore, Harvard Medical School.

October 30—Specialties Section, "Uses and Abuses of Tracheotomy," Dr. Clay W. Whitaker, Cleveland.

Fifth District

(COUNCILOR: GEORGE W. PETZNICK, M. D., CLEVELAND)

ASHTABULA

At the regular monthly meeting of the Ashtabula County Medical Society on September 13, Dr. William Havener, professor of ophthalmology at Ohio State University, presented an interesting and informative talk that was well received and ap-

immortals of chinese mythology:



Chung-li Chu'an

This powerful magician revived the souls of the dead with a wave of his fan and gained a lasting place in Taoist legend

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preciated by attending physicians.—A. F. Uran-
kar, M. D., Secretary.

Sixth District

(COUNCILOR: ROBERT T. TSCHANTZ, M. D., CANTON)

COLUMBIANA

Thirty students submitted entries in the health poster contest sponsored by the Columbiana County Medical Society and the Lake Hope Health Conference Team. A winner in the junior division and one in the senior division each received a \$25 savings bond.

The Society met on September 15 at the Wick Hotel in Lisbon. Dr. William A. Kolozsi, president, presided and Dr. John H. Holzaepfel, Ohio State University, discussed "Diagnosis of Cancer of the Uterus."

MAHONING

Insurance was the theme of the September 22 meeting of the Mahoning County Medical Society in Youngstown. Three local insurance men addressed the meeting and discussed various phases of the subject. They were Henry J. Kannensohn, John B. Morgan, Jr., and Lloyd T. Stillson. A social hour was followed by dinner at the Elks Club.

Moderator was Dr. Asher Randell, chairman of the Insurance Committee of the Society. The program was arranged by Dr. M. H. Steinberg, program chairman, and Dr. M. W. Neidus, president, presided.

The Society jointly sponsored the Postgraduate VD Seminar, September 24, with the local chapter of the American Academy of General Practice and health departments.

STARK

U. S. Representative Frank T. Bow, addressed the Stark County Medical Society on October 8, discussing experiences during this year's session of Congress. The first meeting of the fall season was a combined group of doctors and their ladies, held at the Mergus Restaurant in Canton.

The Stark County Medical Society and the Canton Academy of Medicine, in cooperation with the *Canton Repository*, sponsored the first of a series of public forums on October 14. The subject "Cancer" was discussed from the standpoint of four specialty fields after questions previously were acquired from the public through the newspaper.

Panel speakers were: Dr. Lee C. Underwood, internist; Dr. Sidney Larson, radiologist; Dr. Ralph K. Ramsayer, obstetrician and gynecologist; and Dr. Winfred Dowlin, general surgeon.

Other forum topics include: "The Heart and the

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- **reduces frequency of anginal episodes**
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Note: Because of dramatic relief of symptoms and increased sense of well-being in anginal cases, it is advisable to caution the patient against overexertion.

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A Professional Information Booklet giving detailed information on NIAMID is available on request from the Medical Department, Pfizer Laboratories, Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y.

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Blood Vessels," January 13; and "Arthritis and Rheumatism," March 9.

SUMMIT

The Summit County Medical Society had as guest speaker on September 1, Dr. Harriet P. Dusan, of the Hypertensive Research Center, Cleveland Clinic. Her subject was "Most Recent Methods for Evaluating and Treatment of Hypertension." Dinner was served at the Akron City Club with the meeting following in Akron General Hospital Auditorium.

The Summit County Medical Society with the Auxiliary held the annual dinner dance at the Fairlawn Country Club, Akron, on October 10.

TRUMBULL

The first meeting of the fall season for the Trumbull County Medical Society was a joint dinner with the Woman's Auxiliary at Squaw Creek Country Club on September 16.

The Society was host to the Sixth Councilor Postgraduate Day in Warren on October 21.

Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

BELMONT

The Belmont County Medical Society with the Auxiliary met on September 17 at the Belmont Hills Country Club, where a dinner and program was held.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

SCIOTO

Dr. A. W. Humphries, Department of Surgery, Cleveland Clinic, was guest speaker for the September 14 meeting of the Scioto County Medical Society. His subject was "Low Back Pain and a New Method of Treatment by Anterior Spine Fusions." The evening meeting was held in the dining room of General Hospital, Portsmouth.

The Society met at General Hospital, Portsmouth, on October 12. Guest speaker was Dr. F. L. Mendez, Jr., Cincinnati, who discussed the subject, "Changing Aspects of Pulmonary Emphysema."

Tenth District

(COUNCILOR: ROBERT M. INGLIS, M. D., COLUMBUS)

FRANKLIN

Big event of the Columbus Academy of Medicine for the month was the third annual Clinic Day held in the Veterans Memorial Building, Co-

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lumbus, on October 21. Because of the time element, report of this meeting will be given later.

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

HURON

Dr. Glenn G. Edwards, retired Willard doctor observing his 50th anniversary of graduation from the Ohio State University College of Medicine, was honored Tuesday night (Oct. 6) when a group of physicians from Willard and surrounding area met at his home to present him with a 50-year pin and a certificate of distinction in the practice of medicine from the Ohio State Medical Association.

Dr. Horatio Pease, Wadsworth, councilor of the Eleventh District, made the presentation.—*Sandusky Register-Star-News*.

LORAIN

Forty-seven physicians attended the Lorain County Medical Society meeting at Oberlin Inn on October 13. Dr. James T. Stephens, chairman of the Education Committee which was responsible for the Healthorama Tent at the County Fair, gave the full report of this project to the membership. Fifty-seven physicians gave time to various projects at the Fair, (including

the 910 free first polio shots), and 56 members of the Ladies Auxiliary gave six hours each serving as nurses and staffing the exhibits, which were viewed by some 15,000 persons. Slides of the tent gave greater significance to the report. (A detailed report of this activity will be found beginning on Page 1544 in this issue.)

Evaluating this opportunity of reaching the public with sound medical information and educational exhibits the Society voted to repeat the Fair project in 1960.

Drs. C. C. Brausch (Avon Lake), Howard H. Smead (Lorain) and John P. Jasko (Avon Lake) were elected to active membership in the Society.

Drs. James E. Bruce, John N. Bartone and Joanna Sym were elected to Associate Membership.

The Medical Society School Health Committee (Chairman Dr. I. C. Riggan) has taken the initiative in working with school authorities on the problems in connection with the new School Immunization Law. A sub-committee to facilitate the handling of those financially unable to secure this protection will be under the chairmanship of Dr. Andrew M. Matthey.

The program for November will be on Traffic Safety under the direction of Dr. D. L. Fischer.—C. Ruth Zealley, Executive Secretary.

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Menthol	1.0 mg.
Chloroform	0.02 cc.
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Activities of Woman's Auxiliary . . .

CHAIRMAN PUBLICITY COMMITTEE—Mrs. W. J. Horger,
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(See Page 1458 for roster of officers.)

FALL CONFERENCE

The Woman's Auxiliary to the Ohio State Medical Association held its Fifteenth Annual Conference at the Lincoln Lodge, Columbus, Ohio, on September 15 and 16.

Tuesday, September 15, Mrs. C. A. Colombi, state president, presided at a Board meeting. Reports were given and plans were formulated for the Fall months. Several important dates were announced. The mid-winter Board meeting will be held on January 20, 1960, at the Deshler-Hilton Hotel in Columbus.

The 1960 State Convention will be held May 16-19 at Cleveland. The 1960 National Convention will be June 13-17 at Miami Beach, Fla.

Mrs. R. K. Ramsayer was appointed as chairman of a new Geriatrics Committee. A great need in this field is indicated and stress is to be placed on this phase of Auxiliary work.

A Reception and dinner was held in the evening. The speaker, Mrs. Robert Gorman, director of Ohio Department of Public Welfare, spoke on the "Health Problems of the Aged."

The theme for the Wednesday all day meeting of county presidents, officers, chairmen, and members-at-large was "Annual Kick Off Of the Auxiliary Team for '59-'60." Mrs. George T. Harding III, president-elect, was in charge of the program. She presented the fall conference chairman, Mrs. Charles Pavey and co-chairman, Mrs. Robert Heilman.

The entire program was presented in the form of a football game, quarters, referees, and coaches.

Most of the State Officers took part, present-

ing in a unique manner all phases of Auxiliary work.

The priority goals for the years 1956-1960 are:

1. Community Service;
2. American Medical Education Foundation;
3. Legislation.

Mrs. C. A. Colombi, presided "Around the Buckeye Training Table," a buffet luncheon.

Dr. Frank Mayfield, President of the Ohio State Medical Association, gave a "Pep Talk."

Other guests were Mr. Charles S. Nelson, Executive Secretary, Ohio State Medical Association; Mr. George Saville, OSMA Public Relations director; and Mr. Frank Burrows, Jr., Field Service Director of Safety Board of Chicago.

The Ohio State Medical Auxiliary has had their Fall Kick Off and with Vi Colombi as captain the 1959-1960 team expects to reach its goal. Its services—raising funds, providing volunteer workers, and striving to improve community relations—are dedicated to the Ohio State Medical Association.

COLUMBIANA

The Woman's Auxiliary to the Columbiana County Medical Society was privileged to have as guests: Mrs. Christopher Colombi, state president; Mrs. Myron Thomas, second vice-president; Mrs. Reuben Plisken, state AMEF chairman; Mrs. Ruth Wychgel, *Today's Health* chairman; and Mrs. William J. Horger, state publicity chairman, when they met for a luncheon meeting on September 22, at Timberlanes, Salem. Chairmen for the meeting were Mrs. Carl Lehwald and Mrs. Virgil Hart.

Mrs. A. P. Falkenstein presided. Mrs. William Banfield was named chairman of the committee to study the constitution and by-laws, and to formulate proposals for the rejuvenation. Mrs. Colombi gave a resume of the objectives of the



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Auxiliary. Each of the guests spoke briefly on her work with the Auxiliary.

CUYAHOGA

An executive board meeting of the Woman's Auxiliary to the Academy of Medicine of Cuyahoga County was held on August 27, at the Lake Shore Hotel in Lakewood. Mrs. Frank Meany, president, presided.

Reports were given by officers and committee chairmen on the status of their projects to date. The AMEF Christmas card project is gaining momentum. The East and West Side Bowling Teams are ready to roll when given the signal by their Captains. Eighty Auxiliary members form these two leagues. The Chrysanthemum Ball, to be held November 7, at the Carter Hotel by the Academy of Medicine of Cleveland and the Woman's Auxiliary, will be a benefit with proceeds going to the Poison Center. Auxiliary members are being offered a 10 week public speaking course at the Academy of Medicine of Cleveland by Mr. Robert A. Lang, Executive Secretary. The Drug Sample project is proceeding with an assist from the Medical Assistants Society of Cleveland. Preparations are well under way for the Auxiliary of the OSMA Convention in Cleveland next May.

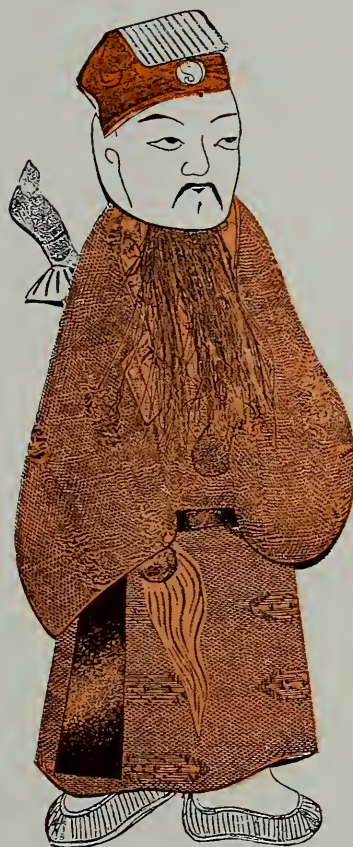
Two practical nursing awards were presented in September by the Auxiliary. On September 15, at John Hay High School, a \$15.00 gift certificate was presented by Mrs. G. E. Gustafson of the Auxiliary to the outstanding graduate of the Jane Addams School of Practicing Nursing. On September 22, a similar award was presented by Mrs. Garry Bassett (Cuyahoga County president-elect) to the outstanding student at the graduation exercises of the Central School of Nursing of Cleveland.

HAMILTON

Members of the Woman's Auxiliary to the Academy of Medicine of Cincinnati who attended the fall conference which was held at Lincoln Lodge in Columbus, Ohio, were: Mrs. Don N. Berning, president of the Woman's Auxiliary to the Academy of Medicine of Cincinnati; Mrs. William C. Ahlering, president-elect; Mrs. Calvin Warner, state treasurer; Mrs. Earl Van Horn, first district director; Mrs. Paul Woodward, state parliamentarian; Mrs. Jerone Janson, chairman of legislation; Mrs. Carl Schilling, chairman of health careers; Mrs. Garfield Suder, chairman of the Christmas card sale, and Mrs. Glenn Weaver, mental health chairman.

Mrs. Garfield Suder, is chairman of the annual Christmas card sale, which is sponsored by the Woman's Auxiliary to the Academy of Medicine of Cincinnati. Proceeds from the sales are given to the American Medical Education Foundation,

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which helps to support the nation's medical schools. This year the committee is also selling personalized stationery and notes.

HURON

The Woman's Auxiliary to the Huron County Medical Society held its September 11 meeting at Fisher-Titus Memorial Hospital, Norwalk, with Mrs. J. D. Braddish serving as hostess.

As a public service, county fire departments are being assisted by this Auxiliary in providing the red and black, luminous emblems used by firemen for quick rescues during emergencies. At this time these emblems are available at no cost to the public.

There were 16 members and two guests present at this meeting.

LUCAS

October was a significant month for Lucas County Auxiliary, highlighting many activities in public relations.

Mrs. Daniel J. Radecki, chairman of the Auxiliary's Toledo Community Chest team and 26 other auxiliary members were entertained at a coffee hour at the home of co-chairman Mrs. John B. Rank. Kits were distributed and instructions were given.

Mrs. C. J. A. Paule, Fourth District director of the Woman's Auxiliary to the Ohio State Medical Association, reported the Fourth District meeting held October 8, at Catawba Cliffs Club near Port Clinton. Mrs. Robert Reeves, president of Ottawa County Auxiliary, introduced the guest speaker, Mrs. C. A. Colombi, state president.

The first auxiliary meeting this season was held October 13, at the Academy building. Mrs. Wilbur A. Taylor, Sr., chairman, and Mrs. H. D. Brown, co-chairman of the luncheon committee, with the help of some seventy ladies prepared and served the auxiliary membership. "Know Your Community" was the topic of the afternoon and panelists consisted of the Toledo city manager, the Toledo mayor, and a member of the board of education. Moderator was Mr. Robert Elwell who is secretary to the Toledo Academy of Medicine. Mrs. Warren A. Nordine and her decoration committee featured timely centerpieces depicting Toledo's nationally famous mall and "Port of Toledo, Gateway to the Sea."

A tea, with Mrs. James M. Dierhelm as chairman, preceded the seventh annual program for the fourteen Paramedical Careers Clubs on October 21, at the Academy Building. Several hundred interested girls attended. Mrs. J. M. Hal-lauer is chairman of Toledo's Paramedical Careers. Mrs. George H. Lemon, auxiliary president,

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awarded this year's scholarship to Miss Carolyn Cornelius, a new student at Mercy Hospital.

Citizens Day Care committee with Mrs. Edward L. Doermann as auxiliary chairman launched the new year with a coffee hour in honor of the volunteer workers on October 26. Mrs. A. J. Kuehm is city chairman of the Citizen's Day Care group.

MAHONING

The Woman's Auxiliary to the Mahoning County Medical Society met September 22, at the home of Mrs. John Noll. Following dessert and coffee, new members were introduced.

Mrs. Arnoldus Goudsmit, program chairman for the meeting, introduced the following panel members for a discussion of Paramedical Careers: Dr. A. E. Rappoport, pathologist, director of laboratories, Youngstown Hospital; Dr. Ivan C. Smith, specialist in physical medicine; Mrs. Jean H. Phillips, personnel director St. Elizabeth Hospital; Miss Marie Kryzan, teacher in social studies and guidance departments, Rayen School.

Serving on the program committee and assisting Mrs. Goudsmit was Mrs. John J. McDonough. The chairman of the social committee was Mrs. Frank G. Kravec assisted by Mrs. J. Allen Altdorffer, Mrs. Lawrence Weller and Mrs. Henry Sisek.

Mrs. A. E. Rappoport, Mrs. Arnoldus Goudsmit, and Mrs. W. H. Evans attended the Fall Conference of the Ohio State Medical Auxiliary which was held at Lincoln Lodge in Columbus.

ROSS

Committees for the year were announced by Mrs. William Garrett, president, at the meeting of the Woman's Auxiliary to the Ross County Medical Society September 3, at the Warner Hotel.

The committees include: American Medical Education Fund, Mrs. L. T. Franklin; Civil Defense, Mrs. Paul MacCarter, Mrs. Howard Wood;

credits and awards, Mrs. Joseph Utrata; legislation, Mrs. Lewis Coppel; mental health, Mrs. Robert Giesler; Health Career Club, Mrs. Joseph McKell, Mrs. Wayne Nusbaum; community service, Mrs. John Franklin; Stork Club, Mrs. Stephen Fleischer; publicity, Mrs. David McKell; radio and TV, Mrs. E. H. Artman; brochures, Mrs. Artman; Mrs. Wood; *Today's Health*, Mrs. Glen Nisley; safety, Mrs. William Corzine Jr.; and auditing, Mrs. Richard Counts, Mrs. Ernest Cutlip.

Mrs. Nusbaum announced Diane Rook will be chairman of the Chillicothe High School Health Career Club.

Prior to the meeting, a salad course was served. Earlier in the evening a social hour for the Medical Society and Auxiliary was held at Dr. and Mrs. Coppel's home, Bearce Road.

SCIOTO

The Woman's Auxiliary to the Scioto County Medical Society held its first fall meeting at Harold's Restaurant with Mrs. Clyde O. Hurst and Mrs. Francis Kulscar as guests.

Following the luncheon, Mrs. A. L. Berndt, president, presided at a business session. Committee chairmen told of plans for their committees during the year.

Mrs. William M. Singleton, director of District 9, reported on the 15th annual conference of the Woman's Auxiliary to the Ohio State Medical Association at Columbus.

Other members who attended the state session were Mrs. Berndt, Mrs. Samuel L. Meltzer, a member of the state nominating committee, Mrs. G. E. Neff, Mrs. Armin A. Melior and Mrs. L. B. Hatch.

STARK

The Woman's Auxiliary to the Stark County Medical Society began its year with a booth at the Treasures 'n Talent Bazaar, October 2 and 3,

(Continued on Page 1586)

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held at the Canton Memorial Auditorium. Gayly wrapped surprise packages were sold for \$1.00 and the proceeds were turned over to AMEF. Chairman for this event was the County AMEF chairman, Mrs. William Rothermel.

The first meeting of the Auxiliary was held in Alliance at the Alliance Woman's Club on October 20. Mrs. William A. McCrea was chairman and Mrs. David Fitzelle was co-chairman. A musical program was given by Miss Judy Warren.

The Annual Benefit Dance, sponsored by the Auxiliary for the benefit of the nurse's scholarship fund will be held November 14. The rotating scholarship for nurses was established by the auxiliary in 1937 and is carried on with funds raised primarily from the annual dance. The committee is headed by Mrs. J. George Tift and assisted by Mrs. James F. Kilduff as co-chairman. Mrs. K. W. Kennedy is Ticket Chairman aided by Mrs. Frank J. Schirack. Mrs. Herbert A. Jones and Mrs. Howard Possner, Jr., decorations; Mrs. Marling L. Abel, publicity; Mrs. Jack Miller is Alliance representative and Mrs. William B. Malloy is Massillon representative.

SUMMIT

The Woman's Auxiliary to the Summit County Medical Society held its Seventh Annual Hat Parade and Garden Party on August 7, at the home of Dr. and Mrs. H. G. Lieberman. Contributing to the success of the garden party were some 400 guests; 12 models, a fashion commentator, 38 committee members, 10 junior hostesses; prizes and refreshments. The party was for the benefit of the Betty King Dobkin Memorial Loan Fund for Nurses. Total profits amounted to \$757.

The Annual Membership Tea was held September 22, at the country home of Dr. and Mrs. T. V. Gerlinger. Seventy-eight Auxiliary members including 15 new members were welcomed.

Symposium on Medical Technology Offered at Cleveland Clinic

Co-sponsored by the Cleveland Society of Medical Technologists, the Frank E. Bunts Educational Institute is giving a Symposium on Medical Technology on November 12 and 13. Attendance will be limited to 125. Special attention will be given to the practical aspects of current and newly developed techniques. The program will be of interest to medical technologists and clinical laboratory supervisors. The program will be at the Cleveland Clinic, 2020 East 93rd Street, Cleveland 6.

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Tucker Asthma Laboratory Closed By Trustees

The following article appeared on September 17 in the *Morrow County Sentinel*:

"The Dr. Nathan Tucker Laboratory in Mt. Gilead, manufacturers of Tucker Asthma Specific, was closed last week it was announced this week by Rudolph Robinson, of Jackson, Miss., trustee of the business.

Mr. Robinson said it was necessary to close the office following the death of his brother, Dr. G. B. Robinson, of Mt. Gilead, who had been managing the business. Dr. Robinson was killed along with William Stewart of Mt. Gilead in an airplane crash near Carey on Sept. 1.

Mr. Robinson said that the Asthma Specific had to be dispensed under a doctor's prescription and for this reason it was necessary to close the business. For the time being mail addressed to the laboratory is being returned to the sender.

Mr. Robinson said that every effort is being made to consummate the sale of the business and if the sale is made the former customers will be notified. The business was owned by a trust and upon the death of Dr. Robinson the management passed to Rudolph Robinson.

The business was founded by Dr. Nathan Tucker in 1889. Dr. W. B. Robinson, father of Dr. G. B. Robinson, took over the management of the business in 1910. Dr. G. B. Robinson became associated with the business in 1925 with his father and was in the business until his death.

Dr. Phillip Benton, who was associated with Dr. Robinson, plans to maintain his office at the Laboratory for the private practice of medicine, Mr. Robinson said. Mr. Robinson said that Dr. Benton will be unable to dispense the Asthma Specific under the terms of the trust.

About six persons have been employed at the Laboratory.

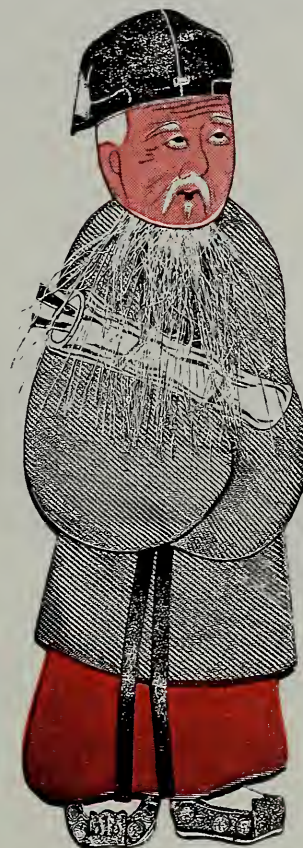
Obstetrics and Gynecology

The Part I Examinations of the American Board of Obstetrics and Gynecology, are to be held in various parts of the United States and Canada, on Friday, January 16, 1960, at 2:00 p. m.

Current Bulletins outlining present requirements may be obtained by writing to the Secretary's office: Robert L. Faulkner, M. D., American Board of Obstetrics and Gynecology, 2105 Adelbert Road, Cleveland 6, Ohio.

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U. M. W. Annual Report Shows Drop in Medical Costs

A slight decrease in hospital and medical care costs for the second consecutive year is shown in the 1959 annual report of the United Mine Workers of America Welfare and Retirement Fund.

The report, for the fiscal year ended June 30, showed hospital and medical care expenditures of \$57,783,116, compared with 1958 figures of \$58,135,684, and 1957 figures of \$59,584,594.

Total fund receipts for the fiscal year were \$132,850,557.93, obtained mainly from the 40 cents a ton royalty which produced \$130,981,039.04. The report shows that royalties were 5.3 per cent below the previous year, and attributed it to high imports of residual fuel oil, natural gas sales in coal market areas, and a severe decline in coal exports to Europe.

Total fund expenditures were \$144,151,266, of which 97 per cent (\$139,877,814) went to 206,946 beneficiaries in 26 bituminous coal states. This consisted of \$78,327 in pension benefits, \$57,783,116 in hospital and medical care benefits, and \$3,767,044 in funeral expense, widows and survivors, and mine disaster benefits. Administrative costs amounted to three per cent of expenditures.

The hospital and medical care expenditures pro-

vided 1,343,893 days of hospitalization for 81,132 beneficiaries, requiring 1,208,159 visits by physicians for medical and surgical services. Additional services of specialists amounted to 1,024,182 office and out-patient clinic consultations. The report stated that more than 7,000 physicians provided services to beneficiaries, largest number of physicians since the program began.

Approximately 1,000,000 beneficiaries currently are covered by the fund's hospital and medical care program.

Holds Physician Immune

In a recent decision, (*Bartlett vs. Weimer*) a U. S. Circuit Court of Appeals in Chicago held that a physician, under Ohio law, cannot be held liable for civil damages as a result of testimony given by him in a lunacy hearing because the physician has a quasi-judicial position in such hearings and therefore has the same immunity as a judge.

Food and Drug Administration is budgeting part of increased funds for law enforcement for stepped up campaign against weight reducing drugs and devices whose effectiveness is misrepresented in labeling. FDA reports most popular commercial items for reducing are electric vibrators.

Poison Information Centers in Ohio

These centers have agreed to cooperate in a program to extend their services to any physician requesting information from them. When a center is called the physician should have four basic facts in mind: (1) The full name or brand of the product ingested or inhaled; (2) An accurate estimation of the amount of the particular agent ingested; (3) The time of ingestion; (4) The age and weight of the patient.

Location	Facility	Telephone
Akron	Children's Hospital W. Bowery and W. Bechtel	BL 3-5531, Ext. 246
Cincinnati	The Academy of Medicine of Cincinnati 152 E. Fourth St.	PA 1-2345
Columbus	Children's Hospital 561 S. 17th St.	CL 8-9783
Cleveland	Cleveland Academy of Medicine 2121 Adelbert Road	CE 1-4455
Springfield	City Hospital E. High St. and Burnett Rd.	FA 3-5531, Ext. 226
Toledo	Toledo Health Department 635 N. Erie St.	CH 4-1961—(Day) GR 9-2244—(Night)
Mansfield	Mansfield General Hospital 335 Glessner Ave.	LA 2-3411, Ext. 248

COMING MEETINGS

American Medical Association, Clinical Session, Dallas, December 1-4.

Cleveland Academy of Medicine, Seminar on Recent Advances in Diagnosis and Therapy of Malignant Diseases, November 18-19.

Medical Technology Symposium, Bunts Institute of Cleveland Clinic, 2020 E. 93rd St., Cleveland, November 12-13.

Ohio State Medical Association, 1960 Annual Meeting, Cleveland, May 17-19.

Fellowships Issued to Ohioans by American College of Surgeons

A number of Ohio physicians were issued Fellowships by the American College of Surgeons at ceremonies during the annual meeting of that organization in Atlantic City. Ohioans announced to receive the designation F. A. C. S. are the following (alphabetical by city):

Akron—William M. Davis and Bruce F. Rothmann; Canton—George Lockhard III and Myrl D. Musgrave.

Cincinnati—Hugh J. Bonner, Clinton H. Buford, Joseph F. Downey, Robert T. Gallagher, George D. J. Griffin II, Robert S. Heidt, Alfred M. Keirle, Jacob J. Longacre, Lester W. Martin, Howard F. C. Pfister, Samuel P. Todd, Jr., Milton Virshup and Lawrence J. Wilchins.

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Heart disease is responsible for about 10,000 deaths a year in the U. S. among children under 15.

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TENTH DISTRICT

DELAWARE—Max W. Livingston, President, 28 North Vernon, Sunbury; Edward C. Jenkins, Secretary, c/o Mrs. Mabel Barrett, Jane M. Case Hospital, Delaware. 3rd Tuesday, monthly.

(Continued on Next Page)

COUNTY SOCIETIES' OFFICERS AND MEETING DATES (Continued)

FAYETTE—H. Wm. Payton, President, 36 S. Main St., Jeffersonville; Marvin H. Roszmann, Secretary, 107 N. North St., Washington C. H. 2nd Tuesday, monthly.

FRANKLIN—James L. Henry, President, 244 E. Park St., Grove City; Mr. William Webb, Executive Secretary, 79 East State Street, Columbus 15. Meetings in January, February, March, May, September, November and December.

KNOX—Henry T. Lapp, President, 4 Public Square, Mt. Vernon; Thomas L. Bogardus, Secretary, 50 Public Square, Mt. Vernon. Quarterly meetings.

MADISON—William T. Bacon, President, 40 E. First St., London. 2nd Wednesday, monthly.

MORROW—Andrew Maciurak, President, 119 E. Main St., Cardington; William S. Deffinger, Secretary, Marengo. First Tuesday, monthly.

PICKAWAY—Henry H. Swope, President, 233 N. Court St., Circleville; Edward L. Montgomery, Secretary, 108 Seyfert Ave., Circleville. 1st Friday, monthly.

ROSS—Robert E. Quinn, President, 30 N. Walnut St., Chillicothe; G. Howard Wood, Secretary, 134 W. Main St., Chillicothe. 1st Thursday, monthly.

UNION—Paul R. Zaugg, President, 130 N. Maple St., Marysville; May B. Zaugg, Secretary, 130 N. Maple St., Marysville. 2nd Tuesday, monthly.

ELEVENTH DISTRICT

ASHLAND—R. Lee Schafer, President, 203 Maple Street, Ashland; Wayne C. Smith, Secretary, 1060 Claremont Ave., Ashland. 1st Friday, monthly, except July, August.

ERIE—Richard F. Hoffman, President, Providence Hospital, Sandusky; Edward P. Gillette, Jr., Secretary, 410 Columbus Ave., Sandusky. Monthly meeting date varies.

HOLMES—Clyde Bahler, President, Walnut Creek; Luther W. High, Secretary, R. F. D. 4, Millersburg. 2nd Wednesday, monthly.

HURON—Walter A. Drury, President, Box 269, Willard; John V. Emery, Secretary, Box 269, Willard. 2nd Wednesday, March, June, September and December.

LORAIN—Denis A. Radefeld, President, 209 Sixth St., Lorain; Mrs. C. Ruth Zealley, Executive Secretary, 311 Elyria Block, Elyria. 2nd Tuesday, monthly.

MEDINA—Robert E. Smith, President, 403 East Liberty St., Medina; William G. Halley, Secretary, 115 Bank Street, Lodi. 3rd Thursday, monthly.

RICHLAND—Riley E. Frush, President, 36 S. Mulberry St., Mansfield; James O. Ludwig, Secretary, 336 Sturges Ave., Mansfield. 3rd Thursday, monthly.

WAYNE—Ralph I. Cottle, President, 230 N. Market St., Wooster; Robert E. Schulz, Secretary, Wooster Community Hospital, Wooster. 2nd Wednesday, monthly.

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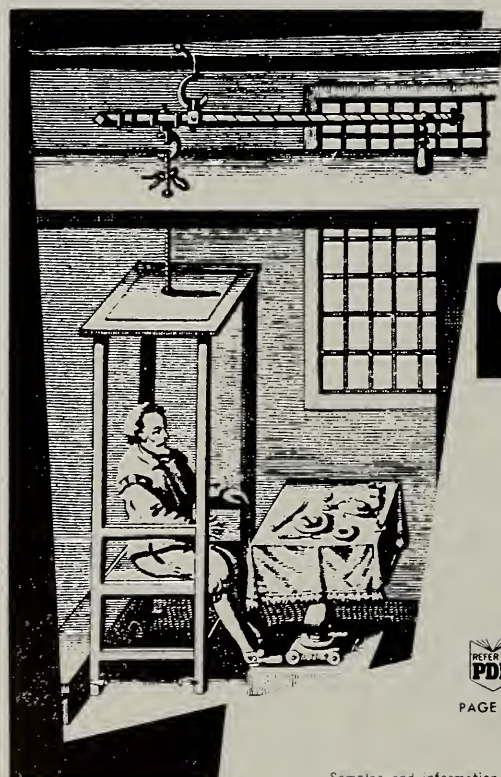
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Sanctorius on his steelyard chair in the act of weighing himself for a metabolism experiment



PAGE 826

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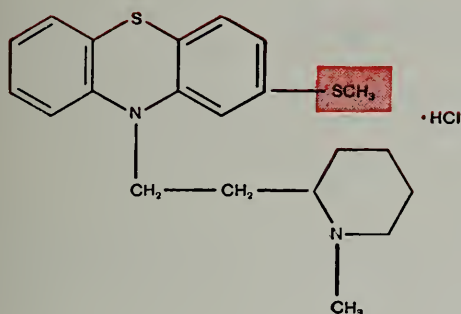
Each GRANUCAP® (Sustained release) capsule contains:

Dextro Amphetamine Sulfate	15 mg.	Vitamin C	30.0 mg.
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Vitamin B-1	1.6 mg.	Sodium Molybdate	0.45 mg.
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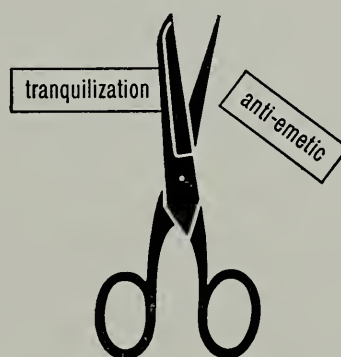
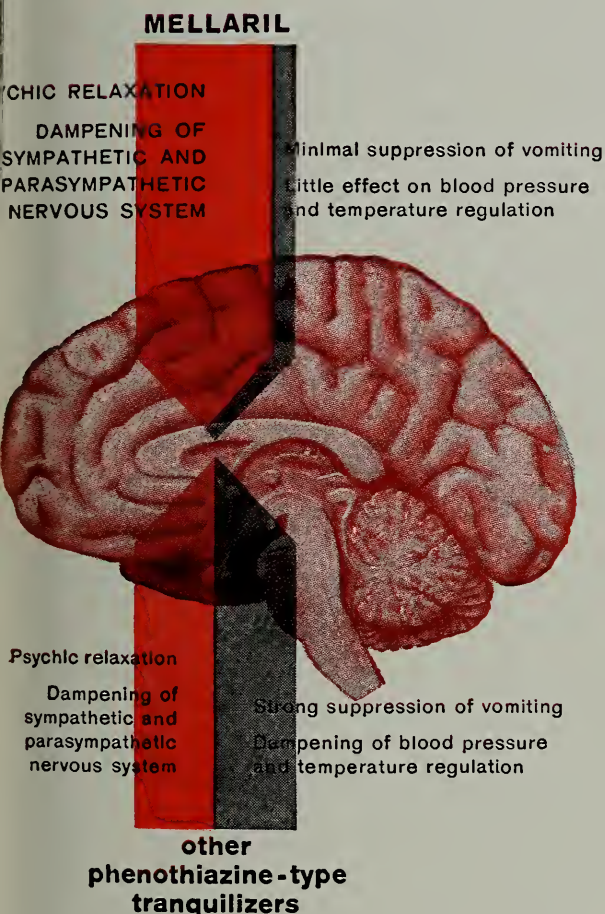
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new advance in tranquilization: greater specificity of tranquilizing action results in fewer side effects



The presence of a thiomethyl radical (S-CH₃) is unique in Mellaril and could be responsible for the relative absence of side effects and greater specificity of psychotherapeutic action. This is shown clinically by:

- 1 A specificity of action on certain brain sites in contrast to the more generalized or "diffuse" action of other phenothiazines. This is evidenced by a lack of appreciable anti-emetic effect.



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- 4 Lack of impairment of patient's normal drive and energy.
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INDICATION	USUAL STARTING DOSE	TOTAL DAILY DOSAGE RANGE
ADULTS: Mental and Emotional Disturbances: MILD — where anxiety, apprehension and tension are present MODERATE — where agitation exists in psychoneuroses, alcoholism, intractable pain, senility, etc. SEVERE — in agitated psychotic states as schizophrenia, manic depressive, toxic psychoses, etc.: <div style="text-align: right;">Ambulatory Hospitalized</div>	10 mg. t.i.d.	20-60 mg.
	25 mg. t.i.d.	50-200 mg.
	100 mg. t.i.d.	200-400 mg.
	100 mg. t.i.d.	200-800 mg.
CHILDREN: BEHAVIOR PROBLEMS IN CHILDREN	10 mg. t.i.d.	20-40 mg.

MELLARIL Tablets, 10 mg., 25 mg., 100 mg.

ttfeld, A. M.: Scientific Exhibit, American Academy
General Practice, San Francisco, April 6-9, 1959



The Physician's Bookshelf

(Books received from publishers. *The Journal* is not obligated to list herein every book received. It will try to list those which appear to be of greatest interest.)

* * *

Year Book of Medicine; 1959-1960, by Paul B. Beeson, M. D., Carl Muschenheim, M. D., Wm. B. Castle, M. D., Tinsley R. Harrison, M. D., Franz J. Ingelfinger, M. D., and Philip K. Bondy, M. D. (\$8.00, *The Year Book Publishers, Inc.*, Chicago 11, Illinois.)

A Doctor's Life of John Keats, by Walter A. Wells, M. D. (\$3.95, *Vantage Press, Inc.*, New York 1, N. Y.)

Sex and Love in The Bible, by William Graham Cole. (\$6.50, *Association Press*, 201 Broadway, New York 7, N. Y.)

Science, Medicine and Morals, by Charles E. Ravens, D. D. (\$3.50, *Harper & Brothers, Publishers*, New York 16, N. Y.)

The Life and Times of Sir Charles Hastings, by William H. McMenemey, M. A., D. M. (\$10.00, *The Williams & Wilkins Company*, Baltimore 2, Maryland, exclusive U. S. agents.)

The Modern Family Health Guide, by Morris Fishbein, M. D. (\$7.50, *Doubleday & Company*, New York 22, N. Y.)

Diseases of Women, by Frederick W. Roques, M. D., John Beattie, M. D., and Joseph Wrigley, M. D. (\$8.00, Tenth edition, *The Williams & Wilkins Company*, Baltimore 2, Md., exclusive U. S. agents.)

Pediatric Pathology, by Daniel Stowens, M. D. (\$20.00, *The Williams & Wilkins Company*, Baltimore 2, Md.)

The Archetypes and the Collective Unconscious: Bollingen Series, Vol. 9, Part I, by C. G. Jung, translator R. F. C. Hull. (\$7.50, *Pantheon Books, Inc.*, New York 14, N. Y.)

Carcinogenesis by Ultraviolet Light, by Harold F. Blum. (\$6.50, *Princeton University Press*, Princeton, N. J.)

Viral Hepatitis: Clinical and Public Health Aspects, by Heinz F. Eichenwald, M. D., and James W. Mosley, M. D. (20 cents. Public Health Service Publication No. 435, *Superintendent of Documents*, U. S. Government Printing Office, Washington 25, D. C.)

High Blood Pressure, by Eugene B. Mozes, M. D. (\$1.45, *J. B. Lippincott Company*, Philadelphia, Pennsylvania.)

Master Your Tensions and Enjoy Living Again, by George S. Stevenson, M. D., and Harry Milt. (\$4.95, *Prentice-Hall, Inc. Publishers*, Englewood Cliffs, N. J.)

The School Health Program, by Alma Nemir, M. D. (\$6.00, *W. B. Saunders Company*, Philadelphia 5, Pennsylvania.)

Current Drug Handbook; 1959-1960, by Mary W. Falconer and H. Robert Patterson. (\$2.75, *W. B. Saunders Company*, Philadelphia 5, Pa.)

Human Relations in Nursing, by Wayland J. Hayes and Rena Gazaway. (\$5.25, Second edition, *W. B. Saunders Company*, Philadelphia 5, Pa.)

How Retarded Children Can Be Helped, by Evelyn Hart. (25 cents, Pamphlet No. 288, *Public Affairs Pamphlets*, 22 E. 38th Street, New York 16, New York.)

Synopsis of Gynecology, by Robert J. Crossen, M. D., Daniel W. Beachman, M. D., and Woodward D. Beacham, M. D. (\$6.50, Fifth edition, *The C. V. Mosby Company*, St. Louis 3, Mo.)

Anatomy and Physiology, by Edwin B. Steen and Ashley Montagu. (\$2.50, Volume 2, *Barnes and Noble, Inc.*, New York 3, N. Y.)

Current Medical References, by Paul J. Sanazaro, M. D. (\$3.50, *Lange Medical Publications*, P. O. Box 1215, Los Altos, California.)

Sex Education for the Growing Family, by Lester D. Crow, Ph. D., and Alice Crow, Ph. D. (\$4.00, *Christopher Publishing House*, Boston 20, Massachusetts.)

Ciba Foundation Study Group No. 1; Pain and Itch; Nervous Mechanisms, by G. E. W. Wolstenholme, O. B. E., and Maeve O'Connor, B. A. (\$2.50, *Little, Brown and Company*, Boston 6, Massachusetts.)

Ciba Foundation Study Group No. 2; Steric Course of Microbiological Reactions, by G. E. W. Wolstenholme, O. B. E., and Cecilia M. O'Connor, B. Sc. (\$2.50, *Little, Brown and Company*, Boston 6, Mass.)

Radiation Therapy, by Walter T. Murphy, M. D. (\$25.00, *W. B. Saunders Co.*, Philadelphia 5, Pennsylvania.)

Surgery of the Ear, by George E. Shambaugh, Jr., M. D. (\$27.50, *W. B. Saunders Co.*, Philadelphia 5, Pa.)

You and Your Public . . .

A Cold Lump-Sum Bill for Professional Services May Shock the Patient, Whereas an Itemized Statement Emphasizes Services Family Has Received

THE little extra time required to itemize statements is one of the best investments physicians can make in building and preserving physician-patient relationship.

An itemized statement tells the patient exactly what he received from his physician in the way of medical services. It makes the patient aware of the care his physician took in diagnosing and treating the patient's ailment. It helps to develop in the patient an appreciation of the fact that medicine is not a pushbutton proposition.

Quality Not Questioned

This is borne out by evidence that a vast majority of patient complaints against physicians does not involve the quality of medical care received, but rather the cost of care. This usually is because the patient does not understand all that is involved in the \$35 or \$40 bill he receives "for professional services."

Most of the complaints that reach grievance committees directly or indirectly are concerned with costs. Further, most of these grievances are settled amicably when the costs are itemized for the patient and explained. In fact, the patient usually goes away with the feeling that he has received a bargain for his money.

Anyone who received a statement from his garage listing \$50 "for professional services" would want to know more about it. He would want to know what parts were replaced, what adjustments were made, what labor charges were involved. Further, the layman knows that his car is repaired simply by driving it. He can tell if he has received value for value.

On the other hand, the layman, it must be remembered, usually cares more about the running condition of his car than about his health. He knows only that he feels good or feels bad. As long as he feels good, he doesn't think about his health. His car is a concrete, tangible object. To him, his health is something he takes for granted—until he loses it.

Understanding Essential

The physician who sends his patient for x-rays or laboratory tests and pays for the tests, then bills the patient, not only should itemize these costs in his statements but should explain them in terms the layman will understand. How many patients would understand his bill if it listed a charge for "cephalin flocculation?" In order to

communicate with the patient, the physician must use a means of communication that the patient understands.

Prepare the Patient

Before the physician sends the patient in for laboratory tests or other diagnostic work, he should be acquainted with just what is to be done, and why it is to be done.

That patient with persistent constipation probably expects to get a laxative and have done with it. Instead, he gets a barium enema. His dignity is hurt and he is upset by this unknown and unexpected development. He is far more reassured if his physician has explained to him the reason for the barium. He feels that he is being given top care when he is made to understand that it is more important to determine the cause of the constipation and treat that rather than to give him only temporary relief.

Then the charges are looked upon by the patient as justifiable, necessary costs instead of "high cost of medical care."

Even better, the physician is performing a service when he explains to the patient the approximate costs before the procedures are carried out. The patient then is mentally prepared to meet these costs. He expects to be billed for them and he understands why he is billed for them.

Memory Is Short

In the case of the head of the family who pays for medical care of his wife and children, there is another strong argument for the itemized statements.

That bill for \$40 "for professional services" sent at the end of the month may be a shocker. However, an item-by-item listing points out to him that Johnny got his polio shot on the 7th, Mary had a bout with a virus on the 12th, resulting in a house call and an office visit for a checkup on the 16th. He is reminded that on the 21st he had his annual physical, while on the 27th his wife dropped in at the office "to get something for my sore throat."

Instead of being irritated by the \$40 "for professional services," he probably will look over the itemized account and think to himself, "That's a lot of medical care for \$40."

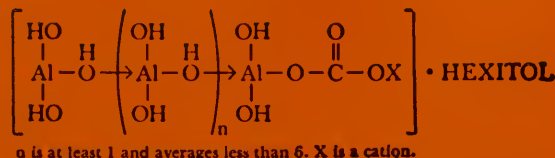
It is a lot of medical care. But he needs to be reminded of it. That's why the case for the itemized statement.

Blood pressure
before Apresoline-Esidrix:

206/118

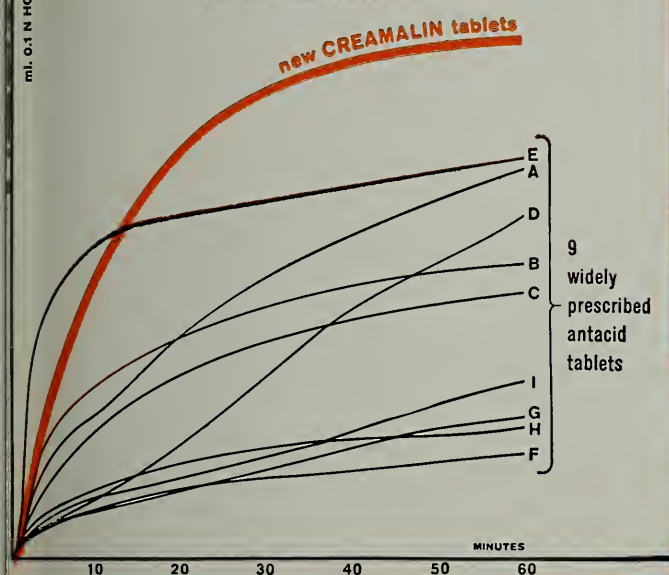
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new high in effectiveness
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CREAMALIN NEUTRALIZES MORE ACID FASTER Quicker Relief • Greater Relief

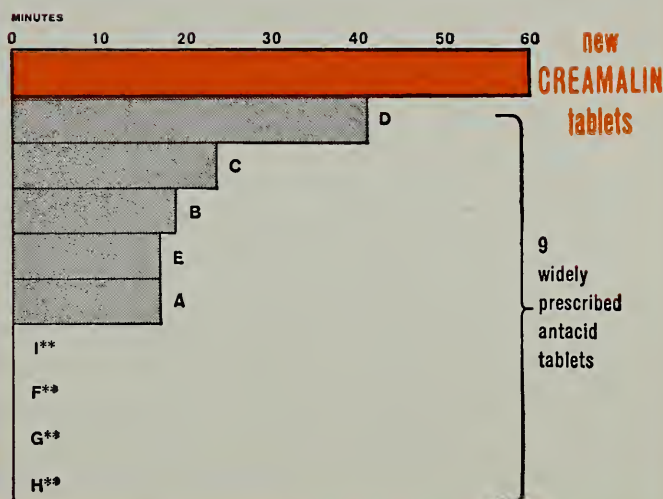
Acid neutralization with 10 leading antacid tablets*
(per gram of active ingredients)



Tablets were powdered and suspended in distilled water in a constant temperature container (37°C) equipped with mechanical stirrer and pH electrodes. Hydrochloric acid was added as needed to maintain pH at 3.5. Volume of acid required was recorded at frequent intervals for one hour.

CREAMALIN NEUTRALIZES MORE ACID LONGER More Lasting Relief

Duration of action at pH from 3 to 5*
(per gram of active ingredients)



*Hinkel, E. T., Jr., Fisher, M. P. and Tainter, M. L.: A new highly reactive aluminum hydroxide complex for gastric hyperacidity. To be published.

**pH stayed below 3.

Do antacids have to taste
like chalk?



No chalky taste. New CREAMALIN tablets are not chalky, gritty, rough or dry. They are highly palatable, soft, smooth, easy to chew, mint flavored.

- NO ACID REBOUND • NO CONSTIPATION
- NO SYSTEMIC EFFECT

Adult Dosage: Gastric hyperacidity: 2 to 4 tablets as necessary. Peptic ulcer or gastritis: 2 to 4 tablets every two to four hours. Tablets may be chewed, swallowed with water or milk, or allowed to dissolve in the mouth.

Supplied: Bottles of 50, 100, 200 and 1000.

Winthrop

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In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

KEEPING TAB ON WHAT GOES ON IN THE OFFICE

"Right Assistant Can Be An Asset," says a heading on an article in the *AMA News*. With that we certainly agree. By the same token, the wrong assistant can practically ruin a physician's relationship with a large number of patients.

Careful screening by the doctor in hiring a receptionist or office assistant is a must. Also, keeping close tab on what goes on in the reception room or on the telephone after the assistant is on the job is also a must.

Sure, the doctor's time must be devoted primarily to treating patients but the physician who loses touch with such matters as to how patients are being handled by the receptionist; how telephone inquiries are being taken care of; how questions about fees are being answered is making a serious mistake. If these, and other matters which could be mentioned, are not taken care of by the office assistant in a manner which creates patient friendship and confidence, then the doctor is in for trouble.

Another point for the physician to remember is that the average patient wants to see and talk to the doctor, not one of his employees. Therefore, an "iron curtain" policy can't help but damage physician-patient relationships.

Good patient relationships start for the doctor in his own office—many times in the front office.

BUDGETS, DEFICITS AND BANKRUPTCY

Elmer B. Staats, deputy director of the U. S. Budget Bureau, has been quoted in the press as warning Congress that increased spending has seriously endangered chances for a balanced budget during this fiscal year and that it looks as if next year's budget will be bigger than the 1959-60 budget.

Seems as if the day has arrived when constituents—including physicians—are going to have to have a bit of a talk with their Congressman, emphasizing that it's time to call a halt on the giveaway stuff.

It's time to call attention to the following statement made by a one-time top Federal official: "The credit of the family depends chiefly on whether that family is living within its income. . . . And that is equally true of the Nation. . . . If the Nation is living within its income, its credit is

good. . . . If, in some crisis, it lives beyond its income for a year or two, it can usually borrow temporarily at reasonable rates. . . . But if, like a spendthrift, it throws discretion to the winds, and is willing to make no sacrifice at all in spending; if it extends its taxing to the limit of the people's power to pay and continues to pile up deficits, then it is on the road to bankruptcy."

The above was uttered by no less than Franklin D. Roosevelt. It's a good observation and warning, even if FDR neglected to live up to it.

SEES DEMORALIZATION PERVADEING SOCIALIZED "HEALTH" IN DENMARK

The would-be socializers like to point with pride to Denmark where statistics indicate one of the healthiest peoples in the world. In a remarkably frank discussion of both sides of the socialized medical and welfare program in that country, *World Health*, publication of the World Health Organization, quotes Danish Dr. Georg Sturup as follows:

"First of all, people from the country come to our cities without going through a period of transition. We house them in little cement compartments, called apartments. Children are hemmed in, relegated to the room on the north—sun, in the opinion of architects, being reserved for the living room. Parents and grandparents cannot live together, the cement compartment is too small for everyone. Children are allowed to run in the streets without supervision on the pretext that nowadays they must be free. How easy it is to get rid of them, justifying oneself with modern theories.

"As you advance in life, you see that everything is cut and dried. For the individual, everything has been foreseen, illness or unemployment are no threat to him. He no longer has to worry about his old age, because he will spend it at 'Gamles By' a de luxe hotel where he will have nothing to do except to discuss who is going to die next. His family won't even have to bother about the details and cost of burying him. Everything has been thought of. Everything is free.

"Social advancement sometimes depends less on the individual and his ability, than on the rules. There is also the possibility of intellectual lassitude leading to melancholy that is the forerunner of psychoses, the mental hospital, even suicide . . ."

Mr. Orla Jensen, director of social services of

*whenever there is
inflammation,
swelling, pain*

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Tablets

conditions
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VARIDASE Buccal provides a simple, natural way to faster, early healing. By activating the fibrinolytic enzymes responsible for normal recovery, VARIDASE shortens the catabolic phase of host response and reverses inflammatory reaction. Edema is reduced.

VARIDASE is not an anti-infective, but by increasing the permeability of the fibrin wall, it eases penetration of natural regenerative factors and fosters healthy tissue growth, making infection less likely.

VARIDASE Buccal Tablets contain:
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Pearl River, New York

Aarhus, summed up the situation by saying: "... our young people emigrate. They go elsewhere to look for the competition that is missing at home."

WHAT DO YOU KNOW ABOUT CONTRACTS?

Sure, physicians are called upon to make and sign contracts like anyone else.

For that reason they must know something about contracts, even before they confer with their own attorney to be sure they don't let their foot slip before getting the lawyer's advice.

The Columbus Better Business Bureau recently issued the following summary of contracts after clearing it with the Columbus Bar Association. Read it; follow it:

Is a contract always identified by a heading and the word "Contract?"

Answer: Contracts or agreements often are not so identified. They are sometimes represented as receipts, sales slips, guarantees, etc. Contracts may be oral or written. The law also recognizes "implied" contracts in certain circumstances. See your lawyer *first*.

Are you entitled to a copy of any contract which you sign?

Answer: Ethically yes, and most reputable concerns will give you a copy. You should make it a point to get and keep a copy of what you sign, *when* you sign.

If one signs a contract without reading it, is it ordinarily binding?

Answer: Your signature on a contract indicates you have read it and understand the terms and conditions. Furthermore, some contracts contain a provision to the effect that no representations other than those in the contract itself shall be recognized.

Are contracts binding which read, "No Verbal Representations are Recognized?"

Answer: The written contract usually holds, unless satisfactory proof is available that you were induced to sign the contract through false or fraudulent representations. Request all oral representations be inserted in the contract *before* you sign.

If an article is repossessed by the seller or voluntarily returned by the purchaser, is the purchaser's obligation ended?

Answer: Most contracts provide that even though an article is repossessed or returned willingly, the customer is obligated to pay the difference between the amount obtained by the seller

in any second sale, on the one hand, and the balance due on the contract, on the other hand.

Is a contract binding (a) if signed on Sunday or a holiday (b) if signed to get rid of a "persistent Salesman?"

Answer: (a) Ordinarily a contract signed on any day is binding. (b) The written contract, signed by both, is usually accepted as evidence of mutual agreement.

Is a contract ordinarily binding when signed in blank and filled in later?

Answer: When you sign a blank contract you, in effect, authorize the seller to fill in his terms. In a clear case of fraud, relief may be obtained through legal action. Have your contract filled in fully *before* you sign.

Does a guarantee mean satisfaction or your money back?

Answer: Not necessarily. Some guarantees are full of loopholes through which the guarantee can be evaded. It is of extreme importance to know and understand the limitations and terms of guarantees. The term, "Guaranteed," when used alone, really means nothing.

The counsel and advice of your attorney is advisable before signing any important document.

ARE YOU LIABLE, OR THE NURSE?

Writing in *Medical Economics*, Emanuel Hayt, LL. B., a nationally known authority on medical and hospital legal problems, listed some broad principles that govern the legal liability of physicians and nurses working in hospitals.

Since these are important to each and every physician, we pass them on with the recommendation that they be well digested by readers of *The Journal*:

- The physician is liable when the hospital nurse acts under his direct supervision and he has had a chance to check her error.

- Both nurse and physician may share the liability if it's proved that he wasn't able to supervise everything she did under his orders.

- The nurse alone is liable only if the physician has no knowledge of her mistake and no connection with it.

- The physician may be held liable for a nurse's error even through hospital "custom" fixes responsibility on the nurse.

- The physician may be held liable for a mistake made even by a hospital-employed nurse-anesthetist.

- Both physician and nurse may be held liable for an accident if the blame can be fixed on neither.

- Exhibits unusual analgesic properties, different from those of any other drug
- Specific and superior in relief of SOMatic pain
- Modifies central perception of pain without abolishing natural defense reflexes
- Relaxes abnormal tension of skeletal muscle

SOMATM

N-isopropyl-2-methyl-2-propyl-1, 3-propanediol dicarbamate

- More specific than salicylates
- Less drastic than steroids
- More effective than muscle relaxants

SOMA has an unique analgesic action. It apparently modifies central pain perception without abolishing peripheral pain reflexes. SOMA is particularly effective in relieving joint pain. Patients say that they feel better and sleep better with SOMA than with previously used analgesic, sedative or relaxant drugs.

SOMA also relaxes muscle hypertonia, with its stresses on related joints, ligaments and skeletal structures.

ACTS FAST. Pain-relieving and relaxant effects start in 30 minutes and last 6 hours.

NOTABLY SAFE. Toxicity of SOMA is extremely low. No effects on liver, endocrine system, blood pressure, blood picture or urine have been reported. Some patients may become sleepy, particularly on high dosage.

EASY TO USE. Usual adult dose is one 350 mg. tablet 3 times daily and at bedtime.

SUPPLIED: Bottles of 50 white coated 350 mg. tablets.

Literature and samples on request.



WALLACE LABORATORIES, NEW BRUNSWICK, N. J.

Washington Roundup . . .

Here Are News Items From the Nation's Capital of Particular Interest To Physicians and Notes on Developments in Medical and Health Fields

FEDERAL AVIATION AGENCY will construct its Civil Aeromedical Research Center in Oklahoma City, slated for completion by June, 1961. Center will include facilities for branches in biophysics, aviation psychology, environmental physiology, diagnostic medical evaluation of pilots, and health service for employees.

* * *

Surgeon General's Consultant Group on Medical Education, after studying picture a year, has recommended to meet demand for additional physicians: larger enrollments at existing medical schools; intrastate and interstate planning of medical training facilities where there are no facilities now, Federal funds for 10-year matching funds program to expand existing schools and build new schools, and more public and private support of schools and scholarships.

* * *

Medicare Director Wergeland forecasts no increase in number of service dependents treated in service hospitals and increase in number cared for by private physicians.

* * *

United States Tax Court holds that a physician's wife who is extremely helpful to her husband in his practice may be considered a partner for tax purposes, even though she is not a physician; also that a patient cannot declare dancing instructions as medical expenses just because his physician said the mild ballroom exercise might be helpful.

* * *

Department of Health, Education and Welfare is cracking down on fly-by-night diploma mills that issue such degrees as "doctorates" in "naturatrics," homeopathy and chiropractic.

* * *

Civil Service Commission has completed organization of new Bureau of Retirement and Insurance to administer Federal employees health benefits program. Employees' organizations have until December 31 to file with Bureau names of health care plans they desire considered as contractual participants.

* * *

Newly established Office of Health and Safety, AEC, is headed by Nathan H. Woodruff, Ph.D.,

who had some years ago an AEC assignment as administrator of technical programs involving medical and biological research.

* * *

Group of expert ophthalmologists picked to modernize eye tests for airmen includes Dr. Benjamin A. Wolpaw, Cleveland. Group's task is to modernize visual standards for Federal Aviation Agency. FAA now denies flight certificates, unless there are mitigating circumstances, in cases involving diabetes, nervous or mental conditions, and heart disease.

* * *

As of August, 1959, Old Age, Survivors and Dependents Insurance payments reached annual rate of \$9,864,000,000, Social Security Administration reports. Checks are mailed monthly to 13,396,000 persons, of which 11 million are 62 or older, some two million are young survivors and dependents, while disability payments go to 300,000 in the 50-64 age group.

* * *

Association of State and Territorial Health Officers has called for large-scale Federal-State studies of atherosclerosis, including assembling of comparable information on influence of saturated and unsaturated fats; increased Federal funds in nationwide hospital planning, and expansion of occupational health services in government employment.

* * *

Veterans Administration, with \$17.3 million appropriated for medical research in fiscal year ending June 30, 1960, plans major emphasis on geriatrics. Most VA hospitals are taking part in cooperative investigations of conditions which assume added importance in an aging population.

* * *

HEW Secretary Flemming reports that a national firm of management consultants has completed analysis of Food and Drug Administration organization. Firm found that FDA was effectively organized and administered.

* * *

American Cancer Society has given \$100,000 grant to U. S. Department of Agriculture to expand research on avian leukosis currently being carried out at Federal facilities in East Lansing, Michigan.



RELA—a new myogestic for better relaxant *and* analgesic therapy—more adept management of spasm and pain in strains, sprains and low back pains.

RELA—though a single drug—is a true myogestic and works rapidly to achieve three desired effects...

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Relief of muscle spasm (96% excellent to good effectiveness)¹

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"Relief from pain was usually rapid and sometimes dramatic"¹

Rela, through relaxation and analgesia, assures daytime ease and nighttime rest

"... A number of patients reported freedom from insomnia which they attributed to freedom from pain."¹

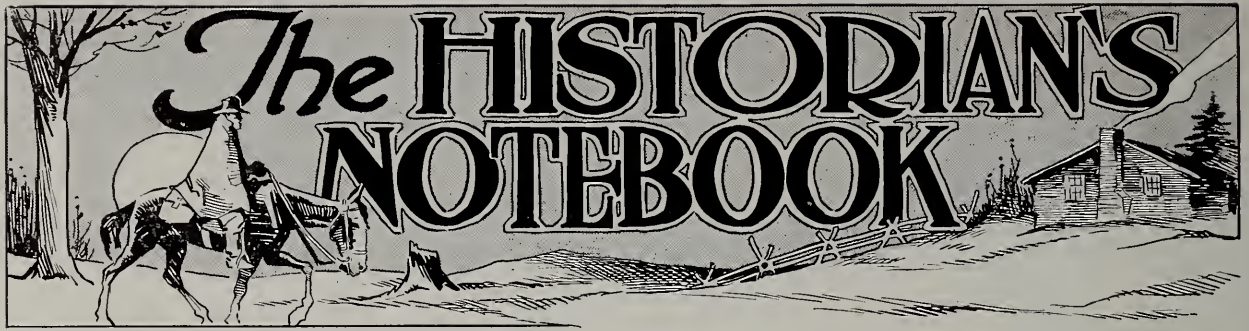
indications: RELA is most beneficial in those conditions of the musculoskeletal system manifesting pain, stiffness and spasm.

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supply: RELA is available as 350 mg., pink, coated tablets in bottles of 30.

1. Kuge, T.: To be published.



Captain Kossuth T. Crossen, M. D.

Patriot, Soldier, Physician

By CHESTER P. SWETT, Lancaster, Ohio

OCCASIONALLY, there emerges from obscurity a person who makes a brief appearance on life's stage. If he conducts himself in such a manner as to win the respect of his friends and neighbors they may honor him so as to perpetuate his memory. Such a man was Dr. Kossuth T. Crossen.

The dedication in 1956 of a new home for the K. T. Crossen Post No. 21 of the American Legion in Athens, Ohio, focused attention again on the man after whom the Post was named. For this Post has the unique distinction of carrying the name of a man who was a Doctor of Medicine and yet served in the army as a non-medical officer. This is also the only Post in Ohio named after a Doctor of Medicine.

Named After a Doctor

Dr. Kossuth Tucker Crossen was born on a farm near Albany, Athens County, Ohio, on June 23, 1878. Appropriately, he was named after the family doctor and friend of the family, Dr. Kossuth Tucker. This was formerly a common custom to name a baby boy after the doctor who delivered him or after a member of the doctor's family. Dr. Crossen's parents were Jacob and Samantha Crossen. The Crossens were of Scotch origin, the original name being Macrossen.

It seems fitting to review briefly Jacob's experience in the Civil War, since it was of some significance in shaping Dr. Crossen's military career. Jacob was born in Fayette County, Pennsylvania, in 1843. His family moved to Ohio when he was eight years old. After his mother's death from typhoid fever the family scattered and he was reared in a foster home in West Virginia. In 1861, at the age of 18, he answered the call for

volunteers by enlisting in the 4th West Virginia Volunteer Infantry.

Father Wounded at Vicksburg

On May 19, 1863, Jacob Crossen was severely wounded in an assault on Vicksburg. He was captured and held prisoner until June 1st. Due to the shortage of food, he was paroled and later sent to a hospital in Memphis. Since his wounds required further treatment he was moved to a base hospital in St. Louis. His most severe wound was of the mandible, involving a submaxillary gland. A salivary fistula developed which drained the rest of his life. After receiving the maximum benefit from the surgery of that period, he was discharged on October 16, 1863.

He returned to Pennsylvania where he married Mary Patterson in 1867. She died in 1869 leaving him one son, named Hugh. He was unfortunate also with his second marriage to Minerva Knight. After three years, she died in 1874. The next year he was married to Samantha Clendennin in Mason City, West Virginia. Within a year or so, they moved to Ohio and settled on a farm near Albany in Athens County. Two children, Kossuth and Mary were born of this union. Kossuth or "Kot" graduated from Albany High School and entered Starling Medical College. He graduated from that institution in 1899.

A Peripatetic Physician

Dr. Crossen returned to Athens County where he opened an office in Carbondale. He practiced there for about 10 years. In 1902, he married Edna Mason. One child, named Burn, was born of this marriage in 1905. This baby, too, was named after the attending physician, Dr. Burn Vorhes of Albany. Misfortune plagued Dr. Crossen, as the baby died when about two weeks old.

Submitted October 1, 1959.

Disagreement and misunderstanding eventually led to a divorce.

After several years he moved to Jerseyville where he practiced for a short time. In 1915, he moved back to his home town of Albany. Here, he renewed old friendships and promptly rented office space from another physician, adjoining the latter's office. This was a most unusual circumstance. Usually a new doctor was discouraged from opening an office by other physicians in the community. If the newcomer ignored the bleak future in store for him as painted by the other doctors, he might be blasphemed, damned with faint praise or vilified by innuendo.

Back to His Home Town

To the credit of the other two practitioners, it can be unequivocally stated that they extended the hand of friendship and professional cooperation. This harmony prevailed until Dr. Crossen entered military service. Since he had been born and reared there, and had returned to his home town, there was scarcely any other attitude for the other doctors to pursue. He was already known as "Kot" to most of the residents. It was not long before he established a satisfactory practice and was apparently quite happy. Perhaps, he was rather clever in renting his office from a doctor. The latter would naturally be interested in having a successful renter.

It was the author's privilege to know Dr. Crossen during his last two years of practice. The doctor often asked him to deliver messages, medicine, flowers, etc. For these services the doctor tipped generously.

Dr. Crossen was of medium height and of a stocky build. His hair was brown, tinged with gray. His eyes were blue, sharp and with a penetrating gaze. His manner was somewhat abrupt and forthright, although warm and friendly. Those who knew him were rewarded with a firm and steadfast friendship.

Early in 1917, when war appeared to be imminent, Dr. Crossen expressed his intention of enlisting. Within a few days after war was declared he applied for a non-medical commission. One wonders why he sought non-medical service. Probably his father's service in the Civil War, with his permanent disability, prompted him to choose the role of a line officer rather than the medical corps.

Thrilled by Civil War Stories

When Dr. Crossen was 12 years old the age of the average Civil War veteran was between 45 and 50. With his father he attended numerous gatherings of veterans at bean dinners, church socials, etc., where he had ample opportunity to hear

those men discuss their military experiences. A lad of 12 listens with rapt attention to such tales. After an interval of 25 years the discomforts are minimized, grief and anguish have been dissipated, and physical pain forgotten. These human emotions are replaced in the mind by amusing incidents, happy events, and pleasant memories. A catastrophe of a quarter of a century ago could be recalled, instead, by a side-splitting side light. The humdrum existence of camp life was usually remembered as an exciting episode, embellished with many comical anecdotes. These experiences undoubtedly made a lasting impression on a growing boy.

With the AEF

It is likely that this association with veterans of the greatest military struggle of modern times up to that time, caused young Kot to be thrilled and imbued with patriotic fervor and the martial spirit. Regardless of his reason, he fulfilled his desire and was sent to the First Reserve Officers' Training Camp at Fort Benjamin Harrison. When he completed this basic training, he was assigned to Co. L. 102nd Infantry with the rank of First Lieutenant. His unit reported to the port of embarkation at Hoboken, N. J., on August 15, 1917. On September 11, 1917, he began active duty with the American Expeditionary Forces.

When Dr. Crossen came home after completing his training, he had lost probably 20 pounds. With this loss of weight he seemingly had gained in stature. He carried himself more erect, and his stride was quick and firm. One gathered the impression that he was immensely proud of his uniform and silver bar. His shiny leather puttees and immaculate uniform added luster to his appearance of being every inch a military man and of taking pride in this achievement.

Probably there are some members of both the military and medical professions who winced when they noted the unorthodox manner in which Dr. Crossen's titles were arranged with his name. This was done deliberately since he, himself, definitely separated the two professions. In the last year of his life, he placed his military career first. Hence, his military rank was put before his name. He chose to make such a decision, so naturally the medical degree was placed last, separated by the name, or the man, himself.

Undoubtedly Dr. Crossen was imbued with one of the greatest and most praiseworthy of human emotions, namely patriotism. In his heart, he could only fulfill his destiny by experiencing actual combat. For this reason, he could do nothing less than decline to accept a commission in the medical corps. This transfer was offered to him during the winter of 1917-18. His superior of-

ficers at the request of officers in the medical corps had urged him to consider it carefully.

Letters Home

In his letters to his friends he was always optimistic of ultimate history. The descriptions of his life in the trenches were notable for the absences of complaints of the hardships. There must have been ample opportunity for him to experience them for he spent four months in the trenches. There was nostalgia in his heart during the Spring when the poppies bloomed and birds began to sing. A passage from one of his letters reads:

"The poppies are in full bloom and are beautiful, red as blood and growing in profusion among the green grass. The fields are also beautifully sprinkled with wild mustard which is yellow when in bloom. Some combinations—red, yellow, and green make a wonderful combination as far as the eye can reach.

"The poppy grows upon the trench and our men walk down lanes of the most gorgeous roses the mind can conceive. The barn swallows are just like the same birds at home in the old shot-up houses where we are now. There they nest by the thousands. They talk the same love-verse to each other as at home and would make a nature lover cry with homesickness. They even get me a little at times."

Fatally Wounded

On June 17, 1918, he accepted a commission as Captain. With this promotion he was assigned to the command of Co. K. 102nd Infantry. This unit participated in the Second Battle of the Marne. It was during this titanic struggle that Dr. Crossen was fatally wounded on July 24th, 1918, near Chateau-Thierry.

He was awarded the French Croix de Guerre with Silver Star, Purple Heart, Victory medal with battle clasps for Chemin des Dames, Toul-Boucq; Pas Fini and Champagne-Marne Defensive Sectors, and the Aisne-Marne Offensive Sector.

After the war, his body was returned to his home county and was re-interred with military honors in the Hebbardsville Cemetery in Athens County.

The following is an excerpt taken from "A Record of the American Legion K. T. Crossen Post No. 21" by Miles Cagg, Post Historian, July 1, 1920: "Those who were personally acquainted with Dr. Crossen knew him to be a virile man of somewhat adventurous disposition, and who loved the truth and despised any form of injustice. He was ready to help those who were in need of help and has gone on errands of charity among those who believed in him and trusted him without thought of compensation."

Hypnosis First Played Role In Religious Rites

Hypnosis has been known for thousands of years and is undoubtedly as old as civilization itself. In ancient times among the Egyptians, Greeks, and Romans it played a role in religious and magic rites and was considered an expression of supernatural powers. During the Middle Ages it was incorporated in the thinking of the era as a manifestation of the malevolent power of witches, sorcerers, and other agents of the devil, with the hypnotized person as the victim of an evil spell.

A more scientific approach to the subject of hypnotism did not evolve until the eighteenth century when Mesmer, a German physician, in 1772 presented his views to the medical profession. However, his theory involved the concept of "animal magnetism" and "universal fluids" passing from one person to another. Although mesmerism became quite the vogue, there was a remnant of medieval mysticism surrounding it. His work was not acceptable to the scientists of the day. He was declared a charlatan and discredited by a scientific commission in Paris which included Benjamin Franklin.

A scientifically more acceptable approach awaited the work of an English physician, Braid, who in the nineteenth century created the term hypnosis to describe the phenomenon he was studying. He discarded the previous physical, magnetic, and physiologic concepts for a psychologic approach.—Hyman S. Barahal, M.D., West Brentwood, Long Island, N. Y.: *New York State J. Med.*, 59: 1552, April 15, 1959.

Some Provisions of the Code of Hammurabi, 2000 B. C.

"If a physician operate on a man for a severe wound with a bronze lancet and cause the man's death; or open an abscess of a man with a bronze lancet and destroy the man's eye, they shall cut off his fingers.

"If a physician operate on the slave of a freeman for a severe wound with a bronze lancet and cause his death, he shall restore a slave of equal value.

"If a physician operate on a man for a severe wound—and save the man's life—he shall receive 10 shekels of silver.

"If a physician set a broken bone for a man or cure his diseased bowels, the patient shall give five shekels of silver to the physician."—quoted by Carter, Richard, in *The Doctor Business*, New York, Doubleday & Co., p. 221.

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Post-Traumatic Epilepsy and the Law

IRWIN N. PERR, M. D.

EPILEPSY is a disease with many legal ramifications.^{1,2,3,4,5,6} Of these, post-traumatic epilepsy is most interesting medically as it is a common sequel to head injury and is thus an important element in assessing damage in personal injury cases. It is often a problem in differential diagnosis and as it is one of the rare diseases which develops long after the injury, predictability is most important. Unfortunately, the average physician sees few such patients and large statistical studies are often contradictory. Therefore, this article attempts to spotlight some of the problems inherent in the subject and to review the relation of injury and epilepsy, recognition and diagnosis, and estimation of the likelihood of epilepsy developing following injury.

Plaintiff's attorneys are well aware that juries will be generous where epilepsy is demonstrated. For example, the most prominent personal injury lawyer in the United States, Melvin Belli, had this to say,⁷ "Traumatic epilepsy may not show itself for as much as 18 years after the damage to the brain. One time the author (Belli) was presented with a case of a 3 month old child, that had been placed in a hospital for surgery on a cleft palate. The day after operation, unaccountably, the child was seen in its bed with a stellate (star) fracture. The recovery was uneventful. A year later the most complete examination revealed not a sign of brain damage. Should settlement be postponed for some 21 years until majority is reached, when there would probably be no chance of sequela (although there have been cases that manifested themselves years later)?"

The Author

● Dr. Perr, Cleveland, is Clinical Director, Fairhill Psychiatric Hospital.

Contrasting significantly is the study of Hyslop⁸ of 750 head injury cases involving litigation. Of these 65 (8.6 per cent) were evaluated for post-traumatic epilepsy; 13 (or 20 per cent) had focal brain damage and verified seizures. In two of these, the seizures occurred in the first six days following injury, with no further attacks and so should not be considered as "epileptic." The other 11 developed within 26 months. The remaining 52 all claimed a head injury of at least a concussional nature. In 12 cases, investigation revealed no injury at all; in three cases there had been merely a laceration of the scalp, with "careful coaching by the claimant's lawyers" (Hyslop's words) to bring in the question of epilepsy. In 18 cases the injury had occurred as the result of a seizure, of these, seven admitted previous attacks and five others were shown to have been diagnosed as epileptics prior to the alleged injury. Four had previous head injuries. Of the 52 without post-traumatic seizures, 28 (or 54 per cent) showed malingering or fraud with respect to the character of the injury or its effects. Thus the number of frankly fraudulent cases outnumbered the true cases of post-traumatic epilepsy by more than two to one.

Frequency of Post-Traumatic Epilepsy

Statistically, post-traumatic epilepsy accounts for about 4 per cent of epilepsy cases as compared,

Read before the Section on Nervous and Mental Diseases at the Annual Meeting of the Ohio State Medical Association in Columbus, April 21-24, 1959.

for example, to almost 80 per cent for idiopathic epilepsy—a 20 to 1 ratio in favor of idiopathic epilepsy. Livingston⁹ reports an incidence of 2.5 per cent in 689 cases whose attacks began after the age of 20, and Lennox¹⁰ records cerebral trauma as the cause of seizures in 5.7 per cent of 2,000 non-institutional cases. A similar report from the Montreal Neurologic Institute¹¹ showed that in 2,000 cases of epilepsy, 4.3 per cent were post-traumatic in origin.

Comments on Pathology

Basically, epilepsy is a disease of the brain; therefore, in order for post-traumatic epilepsy to develop there must be an injury to the brain. Denny-Brown¹² states that "laceration of the brain is an essential factor—whether or not there is injury to the skull." Injuries to the brain are

TABLE 1.—*Epilepsy Following Injury*
(Penfield and Shaver)

Type	Total Cases	Epilepsy	
		Number	Percentage
Scalp Wounds Without Fracture	193	1	0.5%
Concussion, Contusion, or Compression Above	40	0	0
Fracture Without Proven Dural Tear (including subarachnoid hemorrhage)	136	7	5.1
Fracture With Dural Tear	38	3	7.9

primarily of the direct penetrating type or of the contre coup variety. There can be trauma to the head with laceration, concussion, or fracture with no depression—all of which may have little physical effect on the brain. Denny-Brown comments further: "It may be noted . . . how clearly the figures show that fracture of the skull is without importance in the question of epilepsy."

Penfield¹³ states that, "Closed injury to the skull, regardless of its severity, rarely results in post-traumatic epilepsy. . . . The likelihood of epilepsy is greatly increased in case the dura has been penetrated and the brain lacerated by fragments of depressed bone or missile. This is apparently quite independent of the severity of the cerebral concussion and the intracranial hemorrhage which may have attended the injury . . . Brain laceration more often causes seizures than cerebral contusion or closure of a cerebral vessel. Subdural hematoma and internal hydrocephalus never do unless some other local complication is present."¹⁴

Depression of an area of bone in the cranial vault is not necessarily a severe or dangerous happening. The important feature is whether or not the dural lining of the skull is torn by a sharp

edge of bone jutting inwards. Thus, Denny-Brown feels that fracture per se is not especially pertinent to the development of epilepsy and that it is the brain damage itself that is the essential element.

Incidence of Post-Traumatic Epilepsy Following Head Injury

Published reports on the incidence of epilepsy following injury are most contradictory. Analysis reveals that several factors are responsible for this morass of data. There is a great distinction (1) between wartime and civilian studies and (2) between closed and penetrating injuries. In addition, various articles reflect special selections of patients or rather distinguishing circumstances. Thus, one may find reports where the incidence varies from 0.1 per cent to 50 per cent. It is most important then to categorize definitively the group being reported.

Wartime reports from World War I and World War II indicate an incidence of 1.5 to 49 per cent. There are numerous reports which run the gamut between the above numbers. Contrasting with these is the largest single study ever reported by Feinberg¹⁵ in Switzerland—of the civilian population in a 14 year period from 1919 to 1933 in which there were only 50 cases of traumatic epilepsy in 47,130 head injuries, an incidence of 0.12 per cent. This would indicate that epilepsy is less frequent in the head injury group than in the population at large where the usual incidence of epilepsy of all kinds is about 0.5 per cent—an obviously erroneous conclusion.

Ascroft¹⁶ in his well-known study reported in 1939 on 317 cases from World War I. Of these, 34 per cent had seizures. Where there was penetration of the dura mater, the incidence was 45 per cent; where there was not, the incidence was 23 per cent. Many factors are responsible for these figures. First, a large number of persons were included who had seizures immediately following the injury (even if there was only one seizure) without recurrence. Today many would not be considered as "epilepsy." Secondly, many cases were excluded because of insufficient data. Many minor injuries were not included, and neither were patients where the damage was to the cerebellar area of the brain. The group in general was one in which the members were quite severely injured. Another important factor was that these injuries were caused by high velocity missiles which caused great brain damage in contrast to the type of injury received in civil life by the usual type of injury, from a blunt instrument. Some authors have commented on the

inclusion in this series of seizures in the first two or three weeks, as only a small percentage of those patients will become chronic epileptics who have recurring seizures.

Various war studies primarily of penetrating injuries report incidences of 16.5 per cent, 27 per cent, 43 per cent, 44 per cent, 49.5 per cent, and 36 per cent—each study based on a specific type of group. However, the incidences reported from civil injuries are in much lower ranges—apparently averaging about one third of that reported for war injuries. Some are in the range of 0.5 and 2 per cent for closed injuries, not much higher than the incidence of epilepsy in the population at large. Compound fractures are more usually found in war cases and there is a greater difference in result between missile injuries and blunt injuries. Garland and Walter¹⁷ state, "Suffice it to say that the highest incidence claimed is 20 per cent, and the lowest a good deal less than that in the general population; and that it is at least very probable that the first figure relates to a selected group of severe head injuries and the second is diluted with many trivial cases." Seizures following lobotomy occur in 25 per cent, of which 60 per cent is controlled by medication.¹⁸

While open head injuries are reported at 5.5 to 20 per cent, closed head injuries are reported at 2 to 6 per cent with seizures after simple concussion almost unknown. Military reports indicate a higher incidence, but here again one sees the results of high velocity missiles causing injury.

An extremely important report is that of Penfield and Shaver¹⁹ (see table 1) in which there was a total incidence of less than 2.5 per cent in 407 injuries. In fractures with dural tear, the incidence was 7.9 per cent. A striking finding which confirms other reports is the complete absence of post-traumatic epilepsy in 126 brain concussions.

To sum up the statistical situation, reports on incidence vary so much that they are meaningless unless careful attention is directed towards the group described.

The Meaning of Convulsion Soon After Injury

Seizures following injury do not necessarily indicate post-traumatic epilepsy. As Denny-Brown¹² comments, "It should be at least considered whether early convulsions deserve the name traumatic epilepsy or should the term 'immediate traumatic epilepsy' be given some special annotation. There are cases where the diagnosis of epilepsy

was made on a single convulsion in the early stage of severe head injury, without subsequent disability, and where diagnosis interfered with subsequent employment. . . . Because a drug, or electric shock, or anoxia, will provoke a convulsion, it cannot be maintained that 'epilepsy' is thereby produced."

Numerous articles support the belief that seizures shortly after injury are due to a basically different pathologic process from the slow scar formation which is the usual etiologic factor. Minor alterations of consciousness may be due to nervous instability and temporary cerebral ischemia.

Heredity and Post-Traumatic Epilepsy

Although there is a marked familial factor in idiopathic epilepsy, present reports concerning heredity in post-traumatic epilepsy are contradictory. Quadfasel and Walker²⁰ report that families of post-traumatic epileptics show a 4.5 per cent incidence of seizures compared to 3.4 per cent in normals and 17 per cent in families of all epileptics. Some believe that some degree of inherent susceptibility may be present in persons who suffer 'traumatic' epilepsy while others indicate that there is no reason to suppose that the subject of cerebral trauma is more likely to suffer a fit if he has a family history of epilepsy.

Time Interval Between the Injury and the Development of Post-Traumatic Epilepsy

Statistics concerning the relationship between the incidence of epilepsy and the time interval following injury are most important legally. If no epilepsy has developed by the time of trial, the likelihood of such a complication developing may be raised by the claimant's attorney as an element in damages. This is sometimes promulgated by the attorney by the method of pointing out some case where epilepsy developed 15 or 20 years after an injury. Mann²¹ reports a case with a 24 year interval between injury and onset of seizures. In his paper in 1949, he reports finding only five earlier cases exceeding 10 years. His patient had a depressed skull fracture at age three, following a kick in the head by a horse. Diagnosis was confirmed by cure of the epilepsy by surgical extirpation of the traumatized area. Such cases are so rare as to be meaningless statistically, though their intriguing and dramatic qualities are not to be lost in the courtroom.

Phillips²² in 190 cases showed that epilepsy developed in three months in 104 (55 per cent), by one year in 156 (82 per cent), by two years in 162 (85 per cent), by four years in 185 (97 per cent), and all by 11 years. Denny-Brown's¹²

group of 53 showed 42 per cent in one month, and 72 per cent in six months, and 87 per cent in one year. In an Army series,²⁰ 27 per cent developed in three months and 58 per cent by six months. Walker²³ states that 50 per cent develop within nine months, and of those in whom epilepsy develops within five years, 80 per cent have the initial seizure within two years. Jasper and Penfield¹¹ report an incidence of 46 per cent in the first year, 63 per cent in three years, and 80 per cent in five years.

Thus, about 50 to 80 per cent develop in the first year, and about 55 to 85 per cent by two years with a probable figure of 75 per cent for the one and a half to two year period.

Other Factors Concerning Type of Injury

In general, injuries in the parietal area have a higher incidence but this does not differ greatly from temporal and frontal damage. The presence of embedded bone or metal are of no great significance; a probable reason is that larger fragments are removed surgically. With brain infection, incidence is slightly higher. Early surgery, however, does not lower the incidence. There seems to be a definite relationship to periods of prolonged post-traumatic amnesia. In one series,¹⁷ there was a post-traumatic amnesia of more than three hours in 28 of 38 patients. Surprisingly, there is little direct relationship to unconsciousness in that a fair number give no history of unconsciousness at the time of the injury.

Inasmuch as incidence reflects brain damage, one would expect some neurologic confirmation of such damage. Quadfasel and Walker reported a 94.3 per cent incidence with only 14 of 246 patients showing no abnormality on neurologic examination. On the other hand, the presence of severe head injury does not mean that epilepsy will develop. One study²⁴ mentions a head injury group, with no convulsions, that was characterized by greater injuries than the individuals who developed post-traumatic epilepsy.

Some Features of Post-Traumatic Epilepsy

The course of post-traumatic epilepsy is often quite mild with frequent disappearance of the condition. In 207 patients,²³ less than one-half had more than two attacks of any type per year with a lesser number for those with grand mal seizures. In this 10 year follow-up reported by Walker, 47 per cent had no attacks for two years, 36 per cent for five years. Forty per cent of those developing seizures in the first few weeks after injury will have no further attacks. If seizures cease for a year, the chances are four out of five that there will be no seizures in the next five years;

if there is a cessation of attacks for two years, the chances of recurrence are only two in a hundred.

As far as future adjustment is concerned, the greater the neurologic deficit, the greater the disability from such factors as post-traumatic psychosis or neurosis, and the lower the basic intelligence—the more likely is the individual to be handicapped. These seem to be more important than the epilepsy itself.

Post-Traumatic Epilepsy and the EEG

Very briefly, most authorities agree that the electroencephalogram (EEG) is of little help in diagnosis and of much less in the prediction of post-traumatic epilepsy. The slow wave focus indicates localized abnormal cellular activity, but in the majority of such cases, even with penetrating injuries, epilepsy does not result. Abnormal EEG's in the immediate post-trauma period are of no predictability value, nor are nonspecific abnormalities. Paroxysmal outbursts occur in both epilepsy and other head injury cases. Larval epileptic outbursts have greater significance. Most post-traumatic epileptics have abnormal EEG's (possibly 90 per cent) so that the absence of abnormality would be significant. On the other hand, with generalized or bilateral findings, if epilepsy is present, the odds are greatly in favor of idiopathic epilepsy.

The articles by Williams,²⁵ Walker,²³ and Gibbs²⁴ especially review this problem. Gibbs²⁴ compared 125 cases of post-traumatic epilepsy, 215 cases of head injury without convulsions, 1,161 other epileptics, and 1,000 normal patients. Walker²³ summed up the situation with this statement: "Some years ago it was hoped that the EEG would be of diagnostic and prognostic importance in epilepsy. Experience has shown, however, that the brain waves may denote cerebral damage but do not reliably indicate or forecast convulsive complications."

Utilization of Medical Evaluation and Statistics in Expert Testimony

By correlating many articles, certain basic pictures emerge. These can form the basis of mathematical estimation in giving an opinion as to the likelihood of a given complication.

For example, in a civilian head injury caused by a blunt instrument, not a missile (with clear-cut penetration of the skull and dura mater), the incidence of epilepsy will probably not reach 20 per cent. Since at least two thirds of cases develop within a two year period, if by the end of two years when the case comes to trial the patient has not developed clinically provable epilepsy, he now has only a 6-2/3 per cent chance of doing

so. Thus there is an immediate presumption that the odds are 16 to 1 against such a complication.

To return to the case of Belli, the key features were (1) a non-depressed skull fracture, (2) no evidence of penetration of dura or local brain injury, (3) no evidence of abnormal EEG, (4) negative neurologic examination, (5) the passage of a year (6) no history of injury. Briefly, the incidence of post-traumatic epilepsy in such cases is less than 2 per cent (with many neurologists feeling that without local brain injury, there is no relationship). Since more than a majority of cases will develop epilepsy in a year if in fact it will develop at all, the chances are now less than one per cent. Thus the odds are more than 100 to one against the development of epilepsy—odds so low that if epilepsy did develop, it would most likely be a case of idiopathic rather than post-traumatic epilepsy. Without laboring the point, the case now has become a statistical nullity.

Smith⁶ states that the plaintiff in no case can prove probable future occurrence of traumatic epilepsy which has failed to materialize by the time of trial without adducing strong corroborative evidence of impending epilepsy such as significant changes in serial electroencephalograms interpreted and supported by competent neurologic opinion.

Thus the claimant's attorney faces an uphill statistical battle in any effort to indicate probability of occurrence where in fact it has not yet occurred. Walker has suggested that epilepsy insurance rather than compensation be given where there is any reasonable likelihood that epilepsy may occur in the future.

As is apparent from this paper, there is much confusion in this subject—due primarily to the fact that massive statistical studies based on uniform criteria are not available. Therefore, it is suggested that some national group of neurologists and neurosurgeons develop a uniform system of reporting and following up head injuries so that reasonable guesswork can be replaced by statistical computation.

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Indications for Operation In Ulcerative Colitis

The main indications for surgical treatment in ulcerative colitis may be tabulated as follows:

(1) *Absolute Indications*: (a) Regional ulcerative colitis, (b) ulcerative colitis with a more complicated course: polyposis, colonic stricture, massive colonic haemorrhage, perforation of the colon, certain skin and eye complications, incipient parenchymatous damage and arthritis, (c) ulcerative colitis with particularly severe general symptoms: diarrhoea, persistent intestinal haemorrhage, loss of weight, pain, septic temperature, and a pulse rate exceeding 120/min.

(2) *Relative Indications*: Patients who are unfit for work on account of symptoms of ulcerative colitis provoked, *inter alia*, by work.—John Lindenberg, Copenhagen: *Danish Medical Bulletin*, 6:182-185, September, 1959.

The Emergency Management of Maxillofacial Injuries

Anticipation, not desperation, should indicate tracheostomy. Oxygen and its transportation, not sedation, is the therapy of restlessness in the injured. The relative state of consciousness is the window to the injured brain not to be curtained by sedation. Facial bone fractures are easily within reach of the eyes and fingers. Accurate wound closure without tension, not early suture removal, is the key to cosmetic facial scars.—William C. Conroy, M. D., D. D. S., Montclair, N. J.: *J. M. Soc. New Jersey*, 56:538, September, 1959.

Preventive Psychiatry for Industrial Workers*

W. DONALD ROSS, M. D.

THE American Medical Association has made recognition of an important area in public health by establishing a Joint Committee on Mental Health in Industry of the Councils on Industrial Health and Mental Health. Two editorials in *The Journal of the American Medical Association*,^{1,2} which were published at the time of the organization of this committee, indicated the extent of problems in this field and the degree to which responsibility for their solution must fall on family physicians and industrial physicians. The material which follows is an attempt to indicate what can be done by general physicians, in private practice and in occupational medicine, working in collaboration with industrial management and unions, and with various resources in the community, to detect emotional problems among industrial employees at an early stage, and to take steps to prevent more serious psychiatric disorders.

This can be indicated by means of case histories from two hypothetical industries, to illustrate what can be done in comparison with what is too often not done. These will be based on actual instances but disguised beyond recognition whether they come from Cincinnati or elsewhere. We shall give names to the two hypothetical industries. One we shall call Utopian Industries Limited, to be abbreviated U. I. L. The other we shall call the Catch as Catch Can Company, or C. A. C. C. C. Any resemblance to known industries, existent or nonexistent, will be unintentional.

Let us trace the course of several cases in these two industries, beginning with problems which are common in the healthy populations of industrial employment: absenteeism, accidents, alcoholism, executives' problems, fatigue, foremen's problems, and industrial intoxications.

Absenteeism

First, we have two cases of *absenteeism*—one in Utopian Industries Limited, and one in the Catch as Catch Can Company.

• The U. I. L. has a system of absence reporting from the supervisors to the medical department. As a result of this system Mrs. Jones was referred to the medical department for investigation of her frequent absences from work. On the sur-

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face, these appeared to be due to frequent colds and to menstrual difficulties. However, to the industrial physician willing to listen, it appeared that there were other factors dragging down her health.

Her mother had died recently and her aged father was living with them and the employee was really holding down two jobs, one at work and the other in carrying an extra load of housework in comparison with the time when she and her husband were alone. She seemed to be bogged down and unable to see her way out between physical and emotional fatigue. She was on the point of seeking a letter from a private doctor to request sickness disability insurance from the company. This might have appeared helpful to her, although at the expense of the other employees contributing to the insurance plan.

The industrial physician, however, knew that such an arrangement would carry a risk of encouraging prolonged medical disability around a neurosis against returning to work and that the employee would be less happy in the long run. He arranged, instead, for her to have a short period of leave of absence on personal grounds, so that she could catch up without resorting to medical disability, and he encouraged her to return regularly to the medical department to talk with the nurse. The nurse allowed her to ventilate her feelings, about the loss of her mother and about the extra load, and she was soon able to take the step of hiring additional household help and continuing at her skilled job, with more income than she would have had on medical disability, and free from medical symptoms.

• The C. A. C. C. C., on the other hand, also had a case of absenteeism which passed unnoticed for some time. This was a young man working

*Based on a talk presented before the Section on Industrial Medicine at the Annual Meeting of the Ohio State Medical Association in Columbus, April 23, 1959.

as a skilled machinist since his return from military service. No one knew that his absences were the result of efforts to borrow money to cover the debts he had incurred for buying furniture to try to appease his wife with whom he had been quarreling since his return from military service. That is, no one knew this until his wages were garnisheed for his indebtedness. He was still absent frequently to try to raise more money for groceries for his wife and two children, and to attend a skin clinic at a general hospital.

Just at the point where the dermatologist and the social workers at the hospital were on the track of getting him help for his financial difficulties he was fired from his job because of his absenteeism and garnisheement. That helped a great deal. Now he had no job and no good references and very little motivation to do anything but remain on public welfare.

However, between the social workers and the psychiatric clinic of the hospital he and his wife were given help in settling their differences and starting afresh. It was six months before he was able to get a new job, but two years later he was doing well in his new work, was out of debt and saving toward the purchase of a home. The ending was a happy one, but after six months of expense to the community plus free hospital services, and without any appreciable gain to the C. A. C. C. C., who had to train a new man to take his place.

Accidents

Now two cases of *accidents*:

The U. I. L. has a safety program run jointly by the medical and personnel departments and the safety engineers. Attention is given not only to mechanical failure as a cause of accidents, but also to human failure. There is a system of reporting close calls, minor and major accidents, and tracking down the causes of any of these occurring repeatedly in one place or to one person. Any individual having a series of close calls or minor accidents is investigated by the medical and personnel departments.

- Mr. Harris was one such person—apparently recently embarked on a career of being so unlucky as to have all the accidents that started out to happen to somebody else, but he had not yet run into a major accident. The industrial physician found no physical basis for his propensity to close calls, and the psychologist in the personnel department learned that the employee was under considerable tension between recent family difficulties and the attempt to maintain his work output toward the wages for which he was striving on a bonus system of payment for extra production.

A referral to Family Service was arranged for the wife and the worker was shifted to a job on a straight hourly pay basis. The close calls and minor accidents ceased before any loss of limb or life had occurred.

- In the C. A. C. C. C., however, we can see what might have happened to him without such a system. Mr. Smith had had many close calls and a few minor accidents which had passed unnoticed. He was in a similar tense state when he slipped while carrying a large can of concentrated acid. He suffered excruciating pain before first aid was administered. He was rushed to the hospital for the treatment of extensive second degree burns. With appropriate surgical treatment including plastic repairs, paid for under compensation insurance, his physical recovery was very satisfactory. However, he suffered persistent pain and claimed inability to flex the affected limbs. A traumatic neurosis accompanying the painful injury was unrecognized until it had become a chronic compensation neurosis. He saw a lawyer who supported his fear of returning to work by encouraging him to sue for further compensation.

The case dragged on with the patient disabled at home and his family practically destitute pending the outcome of the lawsuit. His wife began running around with another man and his two sons began to engage in petty thievery to get enough to eat. At this stage psychiatric consultation was suggested but the ex-employee had no motivation for psychotherapeutic treatment. The whole family had been tipped over from mental health to mental and social illness.

Alcoholism

On *alcoholism*, or problem drinking, we can be fairly brief:

The U. I. L. has a system of supervisors reporting problem drinkers to the medical department where a checkup is made as to medical or psychiatric factors in the drinking and help offered to the employee, either through Alcoholics Anonymous, through a private physician, the alcoholism clinic in the community, or through a family agency or a clergyman. If the drinking continues, the employee is put on probation, to retain his job only if he seeks help with his drinking problem.

- Mr. A. was one such case. He postponed help on the grounds that he would stop drinking on his own. However, his absences from work after week-ends began to return and a neighbor working in the plant reported that Mr. A's children were begging for food. When he was put

on probation with threat of losing his job he accepted help in the alcoholism clinic. In six months he had given up drinking, joined Alcoholics Anonymous, and was participating with his family in church activities.

- The personnel manager of the C. A. C. C. C. says this company has *no* alcoholism problem because anyone who drinks excessively is fired. That is what he thinks. Mr. B in this company is very similar to Mr. A but his foreman covers up for him. The foreman feels sorry for Mr. B's family and for Mr. B and does not want him to lose his job. He carries the extra load when Mr. B is not there, and gets others to carry it during the one-half man days when Mr. B is not at his best. He even loans money to Mr. B and reasons with him to cut out drinking. But the drinking continues, with wasted production to the firm as well as misery to Mr. B's family, until the foreman loses his patience with Mr. B., stops covering up and has him fired. Mr. B's wife leaves him, and he proceeds on downhill to skid row and to periodic hospitalization with delirium tremens and cirrhosis of the liver.

Executives

Now, what about *executives*?

- The U. I. L. was considering the promotion of an executive to a more responsible position. The medical director had some question about the promotion of this executive because of evidence already of tension and anxiety. He suggested a consultation with the company psychiatrist. The psychiatrist determined that the executive's anxiety was related to his "chafing at the bit" in the position which he had now held for five years. There were some personal problems on which he could use help but there seemed no reason for him to turn down the promotion. He was advised to take it and referred to a psychiatrist, in the city to which he would move, for a period of psychotherapy. The recommendations were followed and four years later the executive was happy and healthy in his job and, furthermore, he was spending more time with his family in spite of his increased responsibilities.

- The C. A. C. C. C. had an executive who was happy in his work except for one thing: his wife was dissatisfied with his status and with their income, and nagging him toward promotion. He got the opportunity for promotion without any assessment of his readiness for it. He had to work a lot harder. His wife was now dissatisfied that he was not home more and she was not doing much to make the home a place he would rather

be than at work. He began to develop ulcer symptoms but postponed going to the doctor. He was now imbued with the "do it yourself" attitude of so many executives and he treated his own ulcer until it perforated—then hospitalization, surgery, more expense, and so on.

Fatigue

Next, in alphabetical order, let us consider problems of *fatigue*:

- At the U. I. L. one conscientious workman was becoming fatigued and irritable. He lodged a "grievance" against his foreman through union channels on the grounds of discrimination in promotion in favor of another worker. The union steward recognized that he had no technical grievance and turned him over to the union counselor. This man was impressed by his story of great fatigue at work and referred him to the medical department for a checkup.

Physical examination was negative but more of the story came out, of resentment against the foreman around the feeling of discrimination, and fear of retaliation by the foreman for this resentment. Furthermore, the foreman had the same first name as the employee's father, who had, in fact, favored the employee's younger sister over him. Only after these feelings had been ventilated in several talks with the doctor was he able to accept the explanation that the foreman was not angry at him but that the other employee had had some previous experience especially qualifying him for the promotion. With advice from the doctor to the foreman to give this employee some special attention, his fatigue and grievance problem vanished.

- At the C. A. C. C. C. Mr. K's work was falling off from increasing fatigue but this was not noticed by foreman or union officials until lateness at getting in to work was followed by absences from work. A warning was given to him with no result and he was fired, all in line with the requirements of the union contract. He then became very discouraged and self-reproachful and unable to get out to look for work.

His wife, doing the best she knew how, went out and got a job herself, leaving him to look after the children. He became increasingly depressed without his wife noticing this since she was too tired when she got home from work to pay much attention to him, or to the children, whose mental health was certainly not being fostered by all this. Finally, he made a suicide attempt and was seen by the family doctor who sent him in to a psychiatric hospital. He recovered soon with the help of shock treatment and had a

new job in a few months. But you can figure the difference in human and economic loss from the case as handled at the U. I. L.

Foremen

The problems of *foremen* will not be presented in detail although they might illustrate several principles of cooperation toward mental health in the industrial environment. The foreman is a particularly key person on whose mental health depends the mental health and economic welfare of many others and he is squeezed between higher management on the one hand, and the workers below him on the other. The U. I. L. has a careful foreman training program and keeps a close watch over the physical and mental health of its foremen. The C. A. C. C. C. has no foreman training program but it is frequently wasting other skilled training on workers who leave the firm or who are promoted to take the place of foremen who can't stand the gaff in one way or another.

Industrial Intoxication

Finally, two case histories of *industrial intoxication* problems will illustrate the need for integrating mental health work in industry with general industrial medical service.

- The U. I. L. includes one process of working with metals which are not irritating to the average worker. However, one worker develops a skin reaction while working in this process. He is referred to the medical department where patch tests show that he is sensitive to the metal. The industrial physician recognizes that a change in occupational assignment will be necessary but that the employee's pay would be reduced in the only assignment available. Furthermore, he recognizes that the patient feels shame and resentment over his skin reaction, fearing that people will believe it is contagious, and needing to sue for compensation to prove that the skin disease is not his own fault. The doctor knows further that the skin reaction may continue after removal from the irritant if these emotional factors are not alleviated also.

The doctor arranges with company and union officials for the man's rate of pay to continue at the same level while he is being trained for another job at a similar rate. The man is given further opportunities to ventilate his feelings. His wife is told the nature of his skin reaction to allay her fears of syphilis, and there are no further sequelae.

- In the C. A. C. C. C., on the other hand, there is a process which includes work with a volatile metal vapor, with no adequate ventilation or at-

mospheric control. One foreman is exposed more than are the rotating workers. He gradually develops fatigue, irritability and social shyness. He quarrels with his wife and spends his evenings in the plant to get away from her complaints about his behavior, thus unwittingly increasing his exposure to the metal. His children are traumatized by the deterioration in the parents' relationships. He develops insomnia and frightening dreams and then a feeling that everyone is against him. He does not see a doctor because he is aware that his ideas are "crazy" and he doesn't want to be found out. Finally he becomes maniacal.

He is seen by a general practitioner who treats him with chlorpromazine, with temporary benefit, and sends him to a State Hospital after he fails to become normal in a few weeks. In the State Hospital organic brain disease is suspected but doubted since chlorpromazine could produce similar effects and since the original cause is not recognized because of lack of information on the patient's working environment. Months later gradual recovery occurs with natural elimination of the metal from the body, but the total experience to the individual and his family has left scars which might have been prevented.

Discussion

These are actual cases with changes only to prevent identification of the individuals and the companies. What I have described as being done by Utopian Industries is far from Utopian. It is being done now in many companies in many communities. Nor are the conditions in the Catch as Catch Can Company beyond the realm of what is happening in many other companies, with subsequent increased cost to the individuals and to the communities.

Some of the economic cost is borne directly by industry in diminished production, wasted training and compensation insurance costs. Some of it is borne indirectly through taxes and charitable donations to institutions and agencies engaged in treatment instead of prevention or maintenance.

The human cost is something else again. When we talk about mental illness, inability to work, or juvenile delinquency, we can feel that these things happen to other people and their children—not to us and those who work with us. But when we give attention to absenteeism, accidents, fatigue and foremen, we can see that these do happen among us, and that they can go on to more serious problems if left unchecked.

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Physiological Aspects of Asphyxia Neonatorum

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TODAY by the application of modern methods of resuscitation many lives are saved in operating rooms throughout the country. Cardiac defibrillation, excitation and massage plus artificial respiration have made possible the salvaging of many lives during surgery. Unfortunately very little of the ingenuity and effort that have been put forth to save adult lives have been expended on the problems of infant resuscitation. Some physicians actually oppose vigorous resuscitation of newborn babies, because of fear of saving a crippled or a retarded child.

An anecdote concerning the Duke of Wellington has some pertinence here. The Duke's famous Peninsular Campaign in Spain lasted for 10 years, and during this time the Duke's army became quite wild in its appearance and habits. Uniforms became ragged and dirty, beards became fierce and shaggy. One day after reviewing a regiment of his near savage soldiers the Duke turned to an aide and said, "I don't know what the enemy will think of them, but by God, they frighten me!" The resuscitative nihilists appear to share the Duke's feelings when they consider asphyxiated babies.

Asphyxia neonatorum is frightening, but in order to understand why this is true, it must be defined in physiologic terms. In the past we have been guilty of vagueness and oversimplification in our thinking about this problem. Now, however, many pieces in this physiologic puzzle are falling into place, and the true picture of asphyxia is slowly emerging.

In the past, degrees of asphyxia have been measured in terms of oxygen saturation of the umbilical vein blood. Low oxygen saturation, however, may be of such brief duration that its only demonstrable effect is cyanosis. In fact, it has been demonstrated that newborn infants may be normal and vigorous in spite of having no measurable oxygen in their arterial blood.¹ This explains why studies which have depended upon blood oxygen saturation as a measure of asphyxia have failed to show any correlation between asphyxia and intelligence quotients in later years of life.^{2,3}

Metabolic Acidosis

On the other hand, prolonged hypoxia in utero and after birth can produce serious altera-

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tions in blood chemistry. The systemic effects of asphyxia are illustrated by Robert Cooke's experiments on newborn lambs. He subjected his animals to asphyxia lasting 10 minutes immediately after delivery and before breathing had begun. He found that plasma pH fell markedly, and that carbon dioxide tension and blood lactate rose to very high levels.⁴ (Table 1.)

TABLE 1.—*Metabolic Effects of Asphyxia Lasting for Ten Minutes in Newborn Lambs**

	At Birth	After Asphyxia For 10 Min.
CO ₂ Tension	75 mm. Hg	150 mm. Hg.
CO ₂ Content	27.5 mEq./L.	24.5 mEq./L.
Lactate	2.5 mM./L.	10.2 mM./L.
pH	7.2	6.7

*Cooke, R. E.: Neurological and Psychological Deficits of Asphyxia Neonatorum, Windle, W. F., ed., Springfield, Ill., Charles C. Thomas, 1958.

Stanley James and his colleagues have confirmed these animal experiments with studies on newborn infants.¹ James found that the vigorous newborn infant, while it might have had a low oxygen saturation, had a relatively normal plasma pH, carbon dioxide tension and reserve of buffer base (bicarbonate, protein and hemoglobin). Depressed infants, on the other hand, had significantly lower pH and buffer base reserves and higher carbon dioxide tensions (Table 2).

TABLE 2.—*Metabolic Effects of Asphyxia on Newborn Infants***

	Vigorous Infants	Severely Depressed Infants
Oxygen Saturation	22.2 %	6.3 %
pH	7.26	7.04
Carbon Dioxide Tension	55.3 mm. Hg	82.0 mm. Hg
Buffer Base (Bicarbonate, Protein, Hemoglobin)	41.5 mEq./L.	31.4 mEq./L.

**James, L. S., et al., J. Pediat., 52:379.

These findings mean that prolonged hypoxia causes a breakdown in metabolic processes. The energy requirements of the body are supplied largely by the oxidation of glucose to produce the end products carbon dioxide and water. When

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oxygen is lacking, glucose can be metabolized only partially, and the end products are lactic and pyruvic acid. These acid products deplete the buffer reserves, and lower the plasma pH. Brief hypoxia raises the carbon dioxide tension, which produces a respiratory acidosis. Prolonged hypoxia floods the system with acid metabolites, and seriously depletes the lifesaving buffer reserves.

Resuscitation of the infant suffering from metabolic acidosis is a prolonged process. Artificial respiration can raise arterial oxygen saturation to normal levels in a short time, but metabolic acidosis persists for long periods. During the recovery period the infant is in critical condition.⁵ These effects of hypoxia are not peculiar to the newborn. Adults also have been shown to suffer the same sequence of events during asphyxia.⁶

Myocardial Failure

The effects of failure of metabolic processes to produce energy is, perhaps, best seen in the functions of the heart. One of the classical signs of distress in the newborn infant is slowing of the heart rate, and all authorities stress the importance of observing this sign. Bradycardia, however, is only the most obvious symptom of heart failure. Irregularities of rate occur usually due to heart block, and progressive failure of the contractile force of the heart muscle causes diminution of cardiac output.⁴ A direct result of heart failure during hypoxia is the decline of the systemic blood pressure, which may fall to 40 mm. Hg. or lower.^{7, 8}

Fetal Circulation

The circulation of the blood of newborn infants must undergo profound changes in order to maintain an independent existence. During fetal life when about half the cardiac output is shunted through the placental circuit there is no need for blood to pass through the unexpanded fetal lungs. The blood returning from the placenta is shunted directly to the right side of the heart via the ductus venosus. In the fetus the right heart pumps more forcefully than the left heart, and the pressure in the pulmonary artery is higher than the pressure in the aorta. This is important for maintaining the pressure gradient through the ductus arteriosus and thus by-passing the nonfunctioning lungs. The by-pass is also aided by the high resistance of the coiled pulmonary arterioles which impede the flow of blood through the lungs. The fetal circulation at term is, therefore, characterized by right ventricular preponderance, high pulmonary artery pressure relative to the aorta, and the ductus arteriosus shunt from the pulmonary to the systemic

circulation. Prompt reversal of these relationships is necessary at the time of birth.

Ductus Arteriosus Shunt

The mechanism which causes the ductus to close after birth is uncertain at this time. Several theories have been advocated, but none have been proved conclusively. It has been shown, however, that in a significant number of babies the ductus remains patent after birth. In most cases it closes within 72 hours,⁹ and in more extreme cases it may remain patent for seven days.¹⁰ This is not functionally important, if the circulation assumes its normal pattern. If the lungs expand properly, the coiled pulmonary arterioles straighten and their resistance falls, and pulmonary artery pressure falls as well.¹¹ If the heart functions efficiently, aortic pressure rises above pulmonary artery pressure, and the pressure gradient in the patent ductus is from left to right. The worst that can happen is for some oxygenated blood to be shunted back through the lungs.

In the asphyxiated infant it seems reasonable to assume that the ductus arteriosus remains patent. One of the most consistent effects of hypoxia in the newborn, as well as in the adult, is a marked increase in pulmonary artery pressure. Thus when hypoxia is present after birth the fetal pressure gradient through the ductus is maintained. If the lungs fail to expand and cardiac failure causes a fall in aortic pressure, the gradient will be quite high. Even though the lungs are expanded, asphyxia causes large portions of the pulmonary artery blood to be shunted to the aorta. The systemic arterial blood is diluted with venous blood, and arterial oxygen saturation falls very rapidly.¹²

Expansion of Fetal Lung

The expansion of the fetal lung is, of course, vital to the survival of the infant, and the frequent occurrence of respiratory distress during the neonatal period has directed much study to this problem. Most of us, I think, tend to regard expansion of the fetal lung in terms of atelectasis of the adult lung. In other words we think of fetal alveoli as being lined with flat, squamous, epithelial cells whose surfaces adhere to one another because of the surface tension of water.

This concept has been challenged by the work of Vernon Krahl. Through the study of transilluminated mouse lungs he has found that the fetal alveoli consist of rosettes of cuboidal epithelial cells in the lumens of which lie small globules of an unknown material. He has shown that this glandular-like structure is easily inflated, by the stretching and flattening of the cuboidal cells to become squamous cells. Thus surface

tension plays no part in the initial inflation of the fetal lung, rather the change of shape of the cells lining the alveolus creates the lumen of the alveolus. Moving pictures which Krahl has taken of this process show that the change in shape of the alveolar lining cells takes place so rapidly that the eye can hardly follow it.^{13,14}

At present no such studies of the initial inflation of the human lung have been made. It would seem likely, however, that the process would be similar in most mammalian species. If such is the case, it must change a great deal of our thinking in regard to neonatal respiratory distress. The term atelectasis should never be applied to the unexpanded fetal lung. When atelectasis is encountered in the newborn it has probably developed following the initial inflation of the lungs. Perhaps, the fetal lung can be inflated with fluid in utero when hypoxia causes the fetus to gasp, and true atelectasis is caused by the absorption of the fluid. Krahl has shown that the mouse lung can be inflated with fluid as easily as by air. Since asphyxia after birth is often preceded by asphyxia in utero, this theory may explain why inflation of the newborn lung is occasionally so difficult. In the great majority of cases the initial inflation of the lungs of an apneic infant can be accomplished with intermittent positive pressure of 20 cm. of water or less. When secondary atelectasis occurs a few hours after birth, however, inflation of the lungs becomes much more difficult.

Respiratory Distress and Pulmonary Function

Respiratory distress, whatever its cause, has direct effects upon the pulmonary function of the newborn (Table 3). The lung capacity of the dis-

TABLE 3.—Comparison of Respiratory Parameters in Normal and Distressed Newborn Infants†

	Normal 2.5 Kg. Infant	Distressed Infants
Minute Volume	498 cc.	+ 75 %
Respiratory Rate	34/Min.	+ 90 %
Tidal Volume	15 cc.	— 8 %
Functional Dead Space	5 cc.	+ 70 %
Alveolar Ventilation	355 cc./Min.	— 30 %
Lung Compliance	5 cc./cm. H ₂ O	— 80 %
Pulmonary Work	1450 Gm. cm.	+ 400 %

†Cook, C. D., et al., *New Eng. J. Med.*, 254:562.

tressed infant is about half that of the normal infant. The tidal volume usually remains normal, but during respiratory distress the physiological dead space increases by about 70 per cent. This means that less air is available to ventilate the alveoli. The infant tries to compensate for its inadequate ventilation by increasing its respiratory rate. Like most mechanical processes, respiration is most efficient at an optimum rate, which in the new-

born infant is in the neighborhood of 34 breaths per minute.¹⁵ As the distressed infant raises its respiratory rate above this level, its lung compliance steadily declines. In other words, the work of ventilating the lungs increases markedly.

Cook and his associates have calculated that ventilation during respiratory distress requires over four times more work than during normal respiration.¹⁶ Thus respiratory distress causes hypoxia, and hypoxia causes impaired metabolic production of energy. It is no wonder that respiratory distress causes physical exhaustion. It is quite possible that the infants in whom no pathology can be found outside the lungs at autopsy have simply died of exhaustion.

Adrenal Cortical Depletion

It is well known that chronic hypoxia causes hypertrophy and depletion of the adrenal cortex. Since hypoxia represents a severe form of stress, it is logical to assume that adrenal depletion occurs in asphyxia neonatorum. Gruenwald has reported necrotic and hemorrhagic destruction of the adrenal cortex in newborns and stillborns which he felt was caused by acute anoxia.¹⁹ It seems quite possible that exhaustion of the adrenal cortex plays a part in asphyxial deaths.

Cerebral Hypoxia

Finally we must consider the effects of hypoxia upon the brain. We know that the brain, and especially the cerebral cortex, is very sensitive to lack of oxygen. Even in mild asphyxia the cortex of the newborn infant is unable to receive sensory stimuli and transmit this stimulation to the respiratory center. The hypoxic breakdown of cerebral metabolism produces a state of coma in the asphyxiated infant which can be relieved only by renewing its supply of oxygen. In more severe states of hypoxia the respiratory center also becomes depressed, and apnea persists until the center can be revived by oxygen.

Treatment of Asphyxia Neonatorum

The asphyxiated newborn infant is seen to be suffering from several closely related derangements of its normal physiology. First, hypoxia causes breakdown of metabolic production of energy, acidosis and depletion of the buffer system. Second, myocardial ischemia causes cardiovascular failure, and maintenance of the ductus arteriosus shunt. Third, depression of the brain causes apnea. Fourth, respiratory distress prolongs the hypoxic state, and leads to exhaustion. Lastly, depletion of the adrenal cortex renders the infant incapable of surviving further stress.

The foregoing review of the physiological effects

of asphyxia neonatorum can now serve as a guide in outlining a logical approach to the treatment of the asphyxiated infant. The first and most obvious measure is to supply oxygen to the infant. Mild states of asphyxia can be reversed by artificial respiration which will aid in expanding the fetal lungs and supply enough oxygen for the brain to initiate spontaneous respiration. In severe states of asphyxia, when true atelectasis exists at the time of birth, high intermittent positive pressure may be required to help expand the lungs. Richard Day who has advocated this approach to resuscitation, feels that inflation of atelectatic lungs requires pressures in excess of 40 cm. of water.¹⁸ Before high pressures can be generally introduced into the field of infant resuscitation, however, more investigative work must be performed, and proper equipment for regulating the very short intervals during which the pressure can safely be applied must be developed.

Another approach to the treatment of acute anoxia is providing oxygen by parenteral means. Intraperitoneal infusions of peroxide solutions have been successfully administered to animals. Injections of aerated compatible blood via the umbilical vein has been suggested. One author has cannulated the umbilical artery and vein and kept an apneic animal alive for an hour with a pump oxygenator.¹⁹ Hypothermia has been advocated as a means of lowering metabolic demands, and rendering the infant less vulnerable to hypoxia. While some of these measures seem logical enough, they are untested in human subjects, and need further investigation.

Servo mechanisms for assisting the respiration of infants suffering from respiratory distress would seem to be a very logical field for future investigation. If the work of respiration produces exhaustion in the distressed infant, mechanical assistance should certainly be of value in relieving the workload and in preventing secondary atelectasis. Here again we must enlist the aid of engineers in providing the proper equipment.

Cardiovascular failure during asphyxia certainly needs more study. It is possible that drug therapy for the failing heart may be of some value. There is one report in the recent literature of intravenous infusion of noradrenalin over a 24 hour period for the specific purpose of raising the systemic blood pressure and reversing the ductus arteriosus shunt.²⁰ Finally, supportive treatment with adrenal cortical steroids may be valuable.

Perhaps, in a few years we will have definitive answers to many problems which are now either vague or unexplored. We have learned much concerning the physiologic derangements of the asphyxiated infant. Now let us hope that we will

soon discover effective methods of treating these derangements. Much work remains to be done, but, at least, we know the directions in which we must search.

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Pyelonephritis of Pregnancy May Be Recurrence of Chronic Disease

Pyelonephritis of pregnancy in some patients represents an acute recurrence of chronic pyelonephritis that has long antedated the pregnancy. In obtaining a history from the pregnant woman, the physician is often placed in a difficult position by an affirmative answer to the question relevant to a past history of "kidney trouble." This nebulous entity, perpetuated by lay medical idiom, includes glomerulonephritis, urethrocystitis, or a postural backache in childhood which some misguided neighbor positively pronounced as being renal in origin. Nonetheless, the burden of proof still rests with the clinician to investigate the patient's urologic status. — Paul L. Getzoff, M. D., and Roger Fowler, M. D., New Orleans: *Southern M. J.*, 52:638, June, 1959.

Institute on Steroid Therapy

Panel Discussion

Edited by NORMAN O. ROTHERMICH, M.D., Columbus, Ohio

THIS panel discussion is a verbatim report of the questions, answers and discussions in the final program of the Institute on Steroid Therapy given at The Ohio State University in January, 1959.* All of the talks were recorded on a tape, but only the panel discussion will be published here. The accompanying speakers comprised the panel, representing only half of those participating in the Institute:

* * *

Dr. Polley: Many of the questions that we have received relate to the general subject of the use and effects of ACTH about which we have had very little discussion; so I think we will begin as a group with this particular phase of the general subject. The first question is: What is the effect of ACTH, should it be used concurrently with steroids or intermittently, and just more or less, what is the rule of ACTH in the corticosteroid program? Let's begin with Dr. Crain.

Dr. Crain: Well, Dr. Polley, I think that we can get pretty nearly the same result with ACTH as we get with most of the steroids, both beneficial and nonbeneficial. The only difficulty is, of course, that ACTH has to be injected intramuscularly or intravenously. Of course, ACTH stimulates the adrenal gland to produce its own cortisone: so whether you have the human produce his own cortisone by stimulating with ACTH or whether you take it off the shelf where Merck has purified it, makes little difference to our way of thinking insofar as the end result on the joint is concerned, except that most patients prefer to swallow a tablet rather than to be injected. There are other differences, of course, that we could elaborate on but I think that this is the essential feature of it.

Dr. Polley: Dr. Rose?

Dr. Rose: I think that this expresses pretty much the view that the allergist would take. There are those who would suggest that patients maintained on ACTH can more readily have steroid therapy withdrawn, but this has not been our experience. One finds that if a patient cannot give up ACTH, he cannot give up orally active steroids and vice versa. The other point which has been raised, namely, the use of ACTH as a priming agent to keep the adrenal intact instead of letting it become atrophied with orally active steroids,

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Participants

- Howard Polley, M.D., Moderator; Consultant in Medicine, Mayo Clinic, Rochester, Minnesota.
- Darrell C. Crain, Jr., M.D., Assistant Professor of Clinical Medicine, Georgetown University, Washington, D. C.
- Geo. J. Hamwi, M.D., Professor of Medicine, The Ohio State University, Columbus.
- Bram Rose, M.D., Associate Professor of Medicine, McGill University, Montreal, Canada.
- Leon Goldman, M.D., Professor of Dermatology, University of Cincinnati, Cincinnati.
- Lewis Sarett, Ph.D., Chief Chemist, Merck Sharp & Dohme Research Laboratories, Rahway, New Jersey.
- Dan M. Gordon, M.D., Assistant Professor of Ophthalmology, Cornell University, New York City.

has no validity because the administration of ACTH, although it stimulates the adrenal, still further depresses the pituitary and you are left very much in the same position as when you started.

Dr. Polley: I would like to ask Dr. Gordon if he has any comments on the subject?

Dr. Gordon: In patients with very severe uveitis, or in individuals with chorioretinitis with macular involvement, I like to use ACTH intravenously and will frequently hospitalize the patient immediately.

Dr. Polley: Dr. Hamwi?

Dr. Hamwi: Everybody is too agreeable today. I am going to argue with Dr. Gordon because I don't think anyone has demonstrated, really, that increasing the dose of ACTH beyond a certain point will permit the adrenal to respond in a more maximal fashion. There is a limit to the response of the adrenal irrespective of the dose of ACTH administered. The only real difference that we know of in the effect of oral corticoids and ACTH is that you stimulate the adrenal to produce other factors than just hydrocortisone. Probably some androgenic activity which may neutralize some of the negative nitrogen balance produced by corticoid. It is important to remem-

ber the time factor in giving ACTH intravenously. For example, if you allow 10 units of ACTH to run in intravenously over a period of six hours, you will probably double or quadruple the response over that if the ACTH had been run in within one hour. But the major point I wanted to make in rebuttal to Dr. Gordon is that there is a definite limit to the adrenal cortical response to ACTH and that this could be exceeded by the administration of corticoids directly.

Dr. Polley: Dr. Goldman?

Dr. Goldman: We previously had used an intravenous ACTH therapy but now we feel that intravenous steroids can do this as well or better. Intravenous prednisalone would be more effective and more immediately accurate; besides there is the allergic reaction to ACTH which sometimes may be quite severe and even cause the death of the patient.

Dr. Polley: I don't believe we have covered that part of the question asking whether ACTH should be used to stimulate the adrenal intermittently during prolonged cortical steroid therapy. I would say no to this question. How do you feel, Dr. Crain?

Dr. Crain: Dr. Polley, may I correct myself on one thing? We haven't before mentioned the matter of acute gout and in this particular clinical problem we prefer ACTH in large doses to that of cortisone.

Dr. Hamwi: I don't see why.

Dr. Crain: I don't either except that cortisone oftentimes makes it worse and ACTH actually helps them. Do you use cortisone in acute gout, Dr. Hamwi?

Dr. Hamwi: We have, but not anymore because we're back to the good, old-fashioned colchicine, but when we did use cortisone we have gotten immediate good response in most of them.

Dr. Polley: To get back to the question at hand, I personally don't believe that it's of any value in giving ACTH to stimulate the adrenal intermittently during prolonged cortical steroid therapy. What is your feeling about this, Dr. Crain?

Dr. Crain: I would agree with that entirely.

Dr. Polley: Dr. Hamwi, will you please discuss the electrocardiographic changes produced by potassium depletion? And we also have a question related to potassium loss in a patient with renal involvement or renal and liver involvement with lupus erythematosus.

Dr. Hamwi: To take the second part of the question first, the patient with lupus with renal involvement—this will vary a great deal with the

extent and nature of the renal involvement. If there is diffuse, extensive tubular disease, there may be considerable potassium loss, but I think this is unpredictable. The depression of the T-wave and the prolongation of the Q-T interval are characteristics of hypopotassemia and should be the things to be watched for.

Dr. Polley: There are many reasons why I am not a dermatologist and here is one of them. Dr. Goldman, in one of the popular women's magazines this year, it stated that cortisone may be used for removal of excess hair. Is this possible? We thought cortisone produced hair.

Dr. Goldman: I am sorry to say that I haven't read this particular woman's magazine. To be brief, I can say that cortisone is of no value in the removal of excess hair. As a matter of fact, it stimulates hair growth but usually in the wrong place, not on the scalp, but in places where women are not likely to want it anyway.

Dr. Polley: Dr. Gordon, there are two questions about the use of atropine in iritis. Apparently in Ohio it is still being done. Would you explain why you stopped using atropine?

Dr. Gordon: It is very hard to shake off things that we have done for 50 to 100 years and so keep doing things in the same way without any good rationale. At one time virtually the only treatment we had for iritis was dilatation of the pupil in order to prevent adhesions of the pupil to the center portion. Today, in view of the action of steroid therapy in the prevention of these adhesions, it is no longer necessary except in a few cases to dilate a pupil after the original examination.

Dr. Polley: Dr. Gordon, do you use skin tests for uveitis before, during or after therapy?

Dr. Gordon: Again I speak against tradition. It has been customary in uveitis, in which we had no treatment, to spend a great deal of the patient's time and money on skin tests in the hope of getting some clues as to the etiology of the particular case of uveitis. Now we realize that the cause of uveitis is completely unknown and hence, such skin testing is of no value.

Dr. Polley: I have another question addressed to the panel in general. I thought Dr. Goldman might start with reference to the use of antibiotics prophylactically in children on steroid therapy. The question is how and what, and is it justifiable to use a program similar to that used in rheumatic fever?

Dr. Goldman: No, in general I would say that it is not necessary to start a routine program with the addition of antibiotics in children who

do not need antibiotic therapy. You see that most commonly in poison ivy and some of the skin infections but we do not institute it unless it is necessary. Antibiotics are powerful medicines. We have certain good theoretical objections besides the objection of using any medicine which is not necessary. We live in a highly endemic area of histoplasmosis and we have seen one case in which the combination of corticosteroids and antibiotics may have contributed to the widespread dissemination of histoplasma in such a young person. I do not like to disturb the balance, that is the normal physiologic, bacteriologic balance, any more than is necessary. Of course, the steroid antibiotic is an important agent too, but should be used only when it is necessary and only when indicated and only as long as indicated. I think the problem of acute rheumatic fever prophylaxis is something else.

Dr. Polley: Dr. Rose, you treat children. What is your opinion about the subject?

Dr. Rose: We do not see a great number of children, Dr. Polley, but occasionally we do use maintenance antibiotic therapy in a child who may or may not be on steroids, particularly a child who has a chest that seems to be compatible with chronic bronchitis and yet isn't, or maybe bronchiectatic and isn't. The only way that we can keep them clear in the rigorous climate of Montreal where the temperature is very low at this time of year, is on maintenance steroid and also on a maintenance dose of one or another of the antibiotics.

Dr. Polley: Dr. Crain, one of your colleagues is quite a vocal advocate of such a program. What do you have to say on this subject?

Dr. Crain: At the clinic we don't see too many children; however if the case happens to be rheumatic fever, of course the patient would be given antibiotics. In children with rheumatoid arthritis we are inclined not to give antibiotics even in the younger ones.

Dr. Polley: I think I would agree with that too. Anyone else want to make any comments on that? Dr. Hamwi, why does the moon face disappear? Is it because steroids suppress the adrenals?

Dr. Hamwi: The moon face appears after treatment and when you lower the treatment or decrease the treatment or the size of the dose, the moon face will tend to disappear. I do want to mention something about the regression of the undesirable side effects, the Cushing-like appearance. You take a case of Cushing's disease and do a total adrenalectomy on it. It may take three to six months for complete regression of all such

signs so when a patient has developed Cushing features on steroid therapy, I don't think it unreasonable to expect that it will take some time for the features of this to disappear even after steroids are discontinued. This applies to hirsutism as well as the moon face.

Dr. Polley: Dr. Sarett, what do we know about the relative adrenal cortical depressing properties of the newer steroids? Is there any preference on this basis?

Dr. Sarett: Dr. Polley, I can speak principally about the laboratory experiments using rats that were injected for six days and then sacrificed. These experiments show that there is no clear-cut differentiation among any of the steroids insofar as experimental animals go as regards the adrenocortical depressing properties. In general, a high degree of correlation has been found between the anti-inflammatory potency of all of the steroids and their ability to suppress the size of the adrenal gland.

Dr. Polley: Dr. Hamwi, do you have any comments in this regard?

Dr. Hamwi: The newer steroids are a little easier to use. They are especially worthwhile in doing the 17 ketosteroid studies on urinary excretion. When hydrocortisone is administered by mouth, about 10 to 20 per cent of it will be metabolised and excreted as a 17 ketosteroid. This may be quite a bit when the patient is receiving 80 to 100 mgs. of the compound by mouth but with the newer steroids which are effective in very small doses, the amount taken in by mouth would have no material effect at all on the total amount of ketosteroid excreted in the urine. As a consequence, we find these newer products far more helpful to us in their use as pituitary and adrenal suppressors as far as the diagnostic point of view is concerned.

Dr. Polley: Dr. Crain, you look like you are boiling up something good. What is on your mind?

Dr. Crain: I hope our audience fully appreciates that Dr. Hamwi is speaking only of experimental or diagnostic work in determining this 17 ketosteroid excretion while the patient is on steroid therapy, but this has nothing to do with steroid therapy in practice.

Dr. Polley: And here is an important question, Dr. Hamwi. In certain articles it has been stated that any patient who has received corticosteroid therapy within 18 months prior to his surgical procedure, should have preoperative cortical steroid.

Dr. Hamwi: There is one report from the Mayo Clinic which seems to be fairly well docu-

mented in which I think Drs. Polley and Spragg—were you two involved in that together?

Dr. Polley: I think I've heard of it.

Dr. Hamwi: In which the patient was subject to surgery six months after the cessation of steroid therapy and went into what was thought to be a fairly clear-cut adrenal insufficiency postoperatively. The report of Wilson in the *Annals of Internal Medicine* about a year or so ago indicated that eight out of ten responded well to an injection of ACTH but two out of the ten did not respond. One would be unresponsive for about two weeks and the other never responding to ACTH. Generally speaking, I think that six months is a good criterion as a part of observation. If a patient has been on steroid therapy for a period of within six months (or any prolonged period of time prior to that), I think it's easier and safer to assume they might potentially have a small chance of developing adrenal insufficiency, and I believe they should be started on steroids in preparation for a surgical procedure.

Dr. Polley: If the patient has any evidences of, or has had any evidences of what we call hypercortisoneism, I would say it should be at least a year and I feel as Dr. Hamwi does, that you had best err on the side of precaution than to take a chance otherwise. Dr. Rose?

Dr. Rose: Instead of answering, I would like to ask a question: What is the minimum amount of time that a patient may be put on steroids, taken off of them and then no longer worry as to whether he can stand an operation? In other words, if the patient comes in in an acute state or with an acute joint or something of the sort, and you put him on a high dose of prednisone, such as 40 mg. daily for four days and then withdraw it in the next few days, do you worry about that patient subsequently?

Dr. Polley: Dr. Rose beat me to it. I was going to ask him that very question.

Dr. Rose: Well, do you?

Dr. Hamwi: No.

Dr. Polley: I think anything beyond three, or four or five days, I would regard as sufficient for adrenocortical suppression. You must realize that the only test of the operative procedure is the operative procedure itself, and you have no way of assaying it despite how long we talked about it up here. It's best to err on the side of precaution if there is any question about it. Now here is a question somewhat related. Does aspirin cause increased production of natural cortisone by the adrenal gland?

Dr. Hamwi: Well, there has been a lot of rumor that it does work the same way, but, on the

other hand I don't think anyone has been able to give any clear-cut convincing evidence that it works through a pituitary-adrenal action.

Dr. Polley: Dr. Crain?

Dr. Crain: I don't know anybody that has managed to get an eosinophil drop from aspirin. I think, probably, that it is an entirely different mechanism although we don't have any idea of just how it would work.

Dr. Polley: Here is a question we might go down the line with—Does prednisone have any advantage over prednisolone as far as you are concerned?

Dr. Hamwi: They function very much the same. I did see somewhere in a paper to the effect that one was superior to the other.

Dr. Polley: Dr. Goldman?

Dr. Goldman: I would say no. The difference of the color of the pills sometimes impresses a patient.

Dr. Hamwi: I agree with the latter statement. There is no difference as far as I am concerned.

Dr. Polley: Dr. Sarett?

Dr. Sarett: I would agree with that too because there is a good deal of theoretical evidence that has been building up in literature that the only active form of any of the steroids is the 11 hydroxy form. 11 keto is reduced as soon as it is present systematically by reducing enzyme and it is reduced to the 11 hydroxy form. Of itself, 11 keto is inert so if you administered prednisone, you would really be administering a biological precursor of prednisalone. Inside of two minutes it would all be prednisalone in the body anyhow.

Dr. Polley: While you are wound up there, here is another one. What do you think of using a maintenance dose of prednisone, for example, 2½ mg. two or three times a day for the control of seasonal hay fever in symptoms that are not adequately controlled with antihistamine?

Dr. Rose: Well, I think it's all right. For those patients (and there are many) who are terribly miserable and who do not respond either to hypsensitivation or antihistaminics, then one is certainly justified in using even as much as 20 mg. of prednisone a day if it appears to be necessary. Generally speaking, one does not advocate it for simple hay fever.

Dr. Polley: I would like to ask Dr. Gordon a question. I hear some rumblings to the effect that he has got some other treatment besides steroids that he uses at times. Do you wish to make any comment about that?

Dr. Gordon: Undoubtedly there are plenty of things besides steroids; however the question of

use of steroids in hopeless cases is a grave one. A physician can do more or less one of two things; he can tell the patient that it is hopeless and give him the old "right arm technique" in which he puts his arm around him, pats him on the shoulder and tells him how sorry he feels for him, or the physician can sit down and say to himself, "Now what do I have in the way of symptomatic therapy which might possibly affect this man's symptoms, and at least for a while, maybe a few years, control this disease?" Steroid therapy, as I point out, is non-specific symptomatic therapy. If you are dealing with edema directly, you might be able to control the situation. There are other things that may have a more specific approach but I don't believe in brushing out the hopeless case. I tried steroid therapy or other types of symptomatic therapy in the hopes of controlling the disease.

For example, in a patient who had already lost vision in one eye with a thrombosis of the central retinal vein, the same condition developed in the other eye and in desperation he was treated with large doses of steroid and made a prompt recovery, winding up with a 20/30 vision in that eye. Now some will claim that you are controlling an inflammatory phlebitis and others claim that the steroid is controlling the edema of the retina, but regardless of the mechanism in that particular patient, it happened to work and he most certainly would have been blind in both eyes otherwise. I have had a number of them, of patients who responded to this type of treatment. On the other hand, I have had some that didn't respond at all but they would have been hopeless anyway.

Dr. Polley: Here is a question we can all tackle as a kind of wind-up. Could you define for us the indications for the use of intravenous steroids with particular respect for two situations: (1) that progressively, hypotensive, toxic, seriously ill, medical patient in whom the efficacy of the antibiotic being used is not yet established and, (2) the seriously ill, postoperative patient in whom wound healing under the most favorable circumstances is uncertain? *Dr. Crain?*

Dr. Crain: My work is confined entirely to the treatment and diagnosis of arthritis and rheumatic diseases and I would call on a good internist for that.

Dr. Polley: What a sneaky way to get out of a question. *Dr. Rose?*

Dr. Rose: Well, I'll be glad to give it a try. Would you mind reading the questions again because they are horribly complicated? What is the first one?

Dr. Polley: Well, the question is, do you have any place for the use of intravenous steroids in the

seriously ill, toxic, medical patient or the seriously ill, toxic postoperative patient?

Dr. Rose: Well, this is a question that is constantly arising and in point of fact I think there is a place, particularly in the postoperative patient where there is a question of some collapse, providing that the patient is reasonably well nursed. Wound healing, as a general rule, is not a great problem and frequently these patients can be pulled through a situation which would otherwise prove very difficult. I don't know what the rest of the panel thinks.

Dr. Crain: Well, I won't duck that entirely. The truth of the matter is we have had similar patients of this sort and who have happened to come to operation when we were interested in them, and we think that there is a place for it, and far more frequently, however, have used intramuscular cortisone. But the intravenous is sometimes lifesaving in such things as severe lupus erythematosus.

Dr. Polley: I think there are many such instances which support that opinion. Anybody else want to comment?

Dr. Hamwi: I did want to make one comment about some experimental work done at another University in which severe shock was produced by the administration of the endotoxin derived from *Escherichia coli* organisms, and he had a very definite severe mortality rate in spite of what seemed to be relatively normal levels of adrenal cortical hormones in the plasma of these animals. When he repeated this experiment, but gave hydrocortisone intravenously along with the injection of the endotoxin, he got a very clear-cut improvement in the survival rate. His inference was that there are certain states or degrees of shock or toxicity to the organism in which the adrenal can respond maximally but the maximum adrenal response is inadequate for that particular situation. This is a concept that is very difficult to lend itself to proof, but I just thought it worthwhile to throw it in at this time.

Dr. Polley: A number of clinical experiences would tend to support this generalization.

We must now bring this panel discussion to a close as our time has run out. I must say we have actually raised more questions than we have answered and obviously there are many unsolved problems. I feel that we haven't given enough emphasis to the matter of dosage and to the susceptibility of the patient, although that has been repeatedly mentioned by the various speakers during the day. However, I think you'll agree that steroids are here to stay and that like any other treatment, the more you learn about using them, the better job you can do. Thank you.

A Clinicopathological Conference

Edited Under the Auspices of the Ohio Society of Pathologists

CHARLES BLUMSTEIN, M. D., *President*

Presentation of Case

THIS was the only University Hospital admission of this 59 year old white man who complained of a short episode of syncope seven days prior to admission, followed by vomiting of bright red blood three days prior to admission. From then on the patient had tarry stools. On the next day he had a second episode of syncope. He was seen by his physician who advised hospitalization.

Approximately four years prior to admission the patient was hospitalized for one month at another hospital because of hematemesis, melena, distended abdomen and pedal edema. Roentgenograms at that time revealed esophageal varices, herniation of the gastric mucosa into the duodenal bulb, and a superficial duodenal ulcer. He refused surgical exploration. He admitted that he drank one to two bottles of beer a week and stated that his appetite was good and that he ate regularly. He gave a history of muscular dystrophy since the age of 43; this was very mild initially, but had progressed to the point that his legs were extremely spastic and painful and he could walk only when supported by a chair or person.

Physical Examination

The patient was mentally confused, pale, and in acute muscular distress. His blood pressure was 160/70, pulse rate 110/minute, respiratory rate 35/minute, rectal temperature 99°F. The mucous membranes were pale without jaundice. Examination of the heart was entirely within normal limits. The lungs were clear to percussion and auscultation. The abdomen was markedly distended; he had a small reducible unilateral inguinal hernia and the abdominal wall showed a marked venous distention. The liver and spleen were not palpable. The bowel sounds were hyperactive and there was a tympanitic fluid wave which was interpreted as ascites. His rectal sphincter tone was good; the prostate was nodular. Both legs showed flexor contractures with muscular spasm and markedly hyperactive reflexes.

Laboratory Data

White blood cell count was 12,200 with 73 per cent neutrophils, 23 per cent lymphocytes, 3

Presented by

- Robert Wall, M. D., Columbus, and
 - Emmerich von Haam, M. D., Columbus.
- Edited by Dr. von Haam.

per cent eosinophils, and 1 per cent monocytes; hematocrit 14.5 per cent; hemoglobin 3.6 Gm.; red blood cell count 2.4 million, with one nucleated red blood cell per 100 white blood cells. *Blood chemistry:* sugar 117 mg.; blood urea nitrogen 30 mg.; prothrombin time 67 per cent; van den Bergh direct 0.3 mg., indirect 1.2 mg.; cephalin flocculation test 1 plus; CO₂ combining power 54 vol.; plasma chlorides 116 mEq.; serum potassium 3 mEq.; sodium 153 mEq.; serum amylase 146 units. Serologic test for syphilis was negative.

His sputum contained gram-positive cocci and gram-negative rods; the culture showed coagulase-positive *Staphylococcus*. Culture of pleural fluid showed a hemolytic coagulase-negative *Staphylococcus*. The urine culture showed a heavy growth of *Proteus* and a few gamma *Enterococci*. Cytological examination of thoracentesis fluid showed erythrocytes and acute and chronic inflammatory cells; no malignant cells were seen. Cytological examination of chylous ascites showed acute and chronic inflammatory cells and mesothelial cells. There were also some cells with large hyperchromatic nuclei which appeared highly suspicious of malignancy.

Hospital Course

The patient received a total of 18 units of blood. He again refused surgery and therefore had to be treated conservatively. He continued to bleed moderately. On his fourteenth hospital day he vomited bright red blood and a Patton tube was put down into his stomach. His temperature rose to 104°F. the same day. He was treated with suction and antibiotics. The tube was removed 48 hours later and the patient's condition seemed improved. On the eighteenth hospital day the patient had abdominal distention and started to

Submitted September 23, 1959.

bleed again. His course went progressively downhill and he expired on his twenty-second hospital day.

Clinical Discussion

DR. WALL: This is a 59 year old man who died 22 days after being admitted to the hospital. He had syncope seven days and hematemesis three days before his admission, and tarry stools from the time of his hematemesis. All that this really tells us is that he had an upper gastrointestinal hemorrhage; the blood flowing down his gastrointestinal tract and showing up as tarry stools, the syncope possibly being related to the acute hemorrhage. He bled actually for three days before we had an opportunity to see him. He had a second episode of syncope five days after his first one and the day before he was admitted.

After all this bleeding he was seen finally by his physician and directed to the hospital. This seems to me an awful late admission for somebody who has had this much trouble, but from his past history we find that this was not new to him, since approximately four years before he had been in another hospital because of the same problems: hematemesis, melena, and a distended abdomen with pedal edema. At that time they found esophageal varices and a superficial duodenal ulcer. Therefore, he had the possibility of bleeding from two sites four years ago.

Prognosis of Bleeding Varices

What are the chances of survival for a man with ascites and hematemesis if we consider that he has esophageal varices obviously related to portal hypertension and hepatic disease? Of such patients with ascites and bleeding, only 50 per cent should survive one year and only 7 per cent should survive five years. Only about 60 per cent of patients with severe hematemesis from varices of the esophagus will survive the first episode of hemorrhage and usually another 30 per cent will survive for one year, although we have all seen patients with esophageal varices who live for a long period of time. So from these considerations we must consider our patient's history at least as unusual.

The patient had also suffered from muscular dystrophy which had been progressive for 16 years. He apparently had a lot of flexion contractions from loss of muscle mass in his lower extremities. When he entered the hospital he was mentally confused but he was apparently not in shock as we gather from his blood pressure recording. His pulse was rapid, his respirations were increased and he was apparently in general distress. He had good clinical evidence for ascites: a hernia which is so common in people with

prolonged ascites, superficial dilated veins over his abdomen, and a fluid wave. His liver and spleen were not palpable, which does not mean that they were not enlarged. If he had this much ascites to be grossly distended it might well be impossible to know whether these organs were enlarged.

His initial laboratory findings merely showed a leukocytosis which would be compatible with his recent hemorrhage. His hematocrit was quite low and he had a comparable hemoglobin and red blood cell count, but his red counts and hemoglobins improved after transfusions up to a level of about 10.8 Gm. hemoglobin and then all of a sudden took a nose dive again concomitantly with the clinical note that he bled again. So any changes in his hemoglobin and red counts were related directly to his transfusions or to the blood losses which were observed clinically. His blood urea nitrogen, strangely enough, was only 30 mg., which is not too much in a patient who has been having tarry stools for three days, and it did not increase too much later on, in spite of the fact that he was continuing to bleed.

I am sort of impressed with the fact that his liver function tests were pretty good. The prothrombin was only a couple seconds off the normal control; his van den Bergh was all right; cephalin was only 1 plus, although this is not a really valuable liver function test; and except for some hypokaliemia, which subsequently was corrected by the surgeon, his electrolytes were not bad. His amylase was 146, which does not particularly help us, and only his bromsulphalein excretion test showed a significant retention at 11.6 per cent. I would think this would be the only really objective evidence we have for liver damage except the evidence of increased portal pressure, such as ascites, and the esophageal varices which were confirmed by the x-ray examination.

His sputum and pleural fluid contained *Staphylococci* which presents such a problem in our hospitals at the present time. From his chart I gather that he had without doubt a significant pneumonia. He had a spiking fever, the laboratory grew *Staphylococci*, and the pulmonary findings were quite compatible with pneumonia.

His ascites was described as chylous which seems important because it means that he had some trouble with his lymphatic drainage. There were cells present which were highly suspicious of malignancy, which in a chylous fluid should make one believe that these suspicious cells were actually malignant cells.

He received 18 units of blood and they put a Patton tube down, a finger-in-the-dike type of approach to hemorrhage from the esophagus, which

worked fine. I think we should remember that patients with a Patton tube obviously do not eat well with a balloon in their esophagus. Some can be fed through the inner lumen of the tube, however regurgitation can lead to aspiration of partially ingested food with possible transient atelectasis and aspiration pneumonias. They took the tube out and about a day or so later he bled profusely again from the same site. Shortly thereafter he died with considerable abdominal distention and pulmonary findings which might suggest terminal pneumonia.

Portal Hypertension

I don't think that clinically one can get any other impression than that this man had some form of increased portal hypertension which was progressive over a four year period of time and then he finally bled from esophageal varices. What could be the cause of this? Obviously the most common cause is cirrhosis of the liver. Only about 50 per cent of these patients have to be heavy drinkers. One can have cirrhosis when one drinks one to two bottles of beer per week, as this man did. This does not speak against this diagnosis and it would seem a little ridiculous to me to make this a chief argument against it. We always worry about the terminal progressive phase of a cirrhotic. Did he develop a superimposed hepatitis that tilted the balance of his equilibrium of hepatic function? We have no evidence of intrahepatic obstruction. Another possibility in cirrhotics is that about 4 per cent of them develop hepatomas. The only evidence that we have to suggest this possibility is the finding of suspicious malignant cells in his "chylous" ascites. Hepatomas are very uncommon in this country as compared with China, India or other Asiatic countries.

Are there any other diseases that can cause a cirrhotic-like picture of this long duration and yet not be classical cirrhosis? I can think of only two. One is Wilson's disease of hepatolenticular degeneration which we usually find in children although it can be present in the third and fourth decades and may be slowly progressive. However, this disease rarely presents the clinical symptoms of portal hypertension. They do present mental confusion and a basal ganglion type of muscular spasticity.

It would be very inviting therefore to suggest that this patient had Wilson's disease and that his progressive muscular disease was not actually muscular dystrophy but caused by his central nervous lesions related to his abnormal copper metabolism. Most of these people have Kayser-Fleischer rings right at the edge of their corneae.

Quite frequently their liver function tests may be nearly normal and the clinching finding is that these people have a tremendously increased copper excretion in the urine. They also have a reduction of a very unusual protein in their blood called ceruloplasmin, which is a copper-transport protein. Whether this man did have Wilson's disease is anybody's guess, I think.

Another heavy metal that produces a cirrhosis-like picture is iron. Could this man have hemochromatosis? We can think about it, since the patient is a man and it would be extremely unusual in a woman. Their cirrhosis can go the way of any other cirrhosis with portal hypertension, ascites, etc. However, there was no pigmentation of his skin and he was not a diabetic. It would be very difficult for me to believe that this man had cirrhosis for four years, severe enough to almost bleed to death and still did not have diabetes. Obviously the important test to rule out this diagnosis would be a serum iron, which was not done.

Portal Vein Thrombosis

There is a distinct possibility that he may have had no cirrhosis but portal or splenic vein thrombosis. Primary splenic vein thrombosis would be very unusual for this duration of time, however it is a possibility, since it may come on very insidiously. It would seem to me a great tragedy if this is what he had, because four years ago he could have been operated upon and cured. He was obviously in no shape for surgery at this last admission. Four years ago nobody was doing splenoportograms but now we can get pretty good pictures of vascular obstruction with splenoportography. He also could have cirrhosis of the liver with portal hypertension and then developed thrombosis of the splenic vessels as a terminal event.

In conclusion, I believe that he had portal hypertension on the basis of cirrhosis of the liver with the possibility of a primary hepatoma. If we really accept these malignant cells in his chylous ascites fluid we would have to suggest that he has developed a hepatoma superimposed on his longstanding cirrhosis. I also believe that he had terminal pneumonia and I am not suggesting it because everybody has it at autopsy, but I would think that he had a specific bacterial pneumonia. These are my final diagnoses; I know of no other.

Clinical Diagnosis

1. Cirrhosis of the liver with ascites and bleeding esophageal varices.
2. Hepatoma (?)
3. Bronchopneumonia.
4. Muscular dystrophy.

Pathological Diagnosis

1. Splenic vein thrombosis with ascites and bleeding esophageal varices.
2. Aspiration pneumonia.
3. Septicemia.
4. Muscular dystrophy.

Pathological Discussion

DR. VON HAAM: The gross autopsy showed a markedly distended abdomen which contained 4000 cc. of yellow cloudy fluid. The pleural cavities contained about 200 cc. fluid each. The heart was normal in size and showed moderate dilatation of the ventricles. The lungs showed partial atelectasis and the bronchi contained aspirated gastric contents. The spleen weighed 425 grams and was soft and mushy. The splenic vein was completely occluded by an organized thrombus which was partially calcified. The liver weighed 1700 grams and appeared grossly normal. The pancreas was normal. The esophagus showed multiple varicosities; the mucosa appeared ulcerated. The stomach mucosa appeared atrophic. The large intestines were filled with semi-liquid tarry material. The remaining organs showed no gross pathology.

Microscopic Examination

Sections from the heart and lungs showed abscesses with bacterial colonization. Sections from the liver showed no evidence of cirrhosis or any other disease. Sections from the spleen showed severe congestion with fibrosis of the pulp, some recent infarcts and areas of iron-calcium incrustation (Gandy-Gamna nodules). Sections from the splenic vein showed a progressive thrombosis, partially organized, partially recent. The vessel wall showed inflammatory changes of nonspecific chronic phlebitis. Sections from the esophagus showed severe submucosal varices with ulceration of the overlying mucosa. The stomach appeared only moderately atrophic. The kidneys showed mild chronic pyelonephritis.

In summary then, our diagnosis was that of primary thrombophlebitis of the splenic vein causing venous obstruction within the portal system with esophageal varices and ascites. It is the "tragic diagnosis" Dr. Wall referred to. The negative liver tests were borne out by the finding of a normal liver. The chylous appearance of the ascites was probably produced by a mild lipemia since the patient always ate regularly, in contrast to patients with liver cirrhosis who lose their appetites. The suspicious looking cells in the ascites were mesothelial cells changed under the influence of anoxia, which is a common source of

error in our cytological evaluation of ascitic fluids in patients with portal hypertension.

DR. WALL: A liver biopsy, in view of the normal liver function tests and the portal hypertension followed by a splenoportogram, would have clinched the diagnosis and saved this patient's life. The patient's refusal of surgery at the other hospital four years ago proved his doom. I remember a similar case when a man came in bleeding like this and we quickly did liver function tests which were all normal. Within 36 to 48 hours we did a splenoportogram and in another 12 hours we had his spleen removed. He went home in seven days and has been fine ever since.

DR. VON HAAM: I think there is one more possibility worth mentioning. I am not too happy about his massive ascites which I cannot fully explain by his splenic vein thrombosis. In a recent article in the *New England Journal of Medicine* a similar case was described in which numerous small arteriovenous aneurysms in the liver were responsible for portal hypertension. The liver appeared normal grossly and microscopically and there was no thrombosis within the portal system. The condition was recognized by hepatic vein catheterization which revealed an increased oxygen content in the blood of the hepatic vein. This certainly represents a very keen diagnosis of a very unusual cause of portal hypertension.

Revascularization of Ischemic Kidney In Hypertension Due To Renal Artery Stenosis

Four cases of renal artery stenosis with hypertension are described where revascularization of the ischemic kidney was attempted rather than the previously employed technique of nephrectomy. Salvage of the relatively normal "ischemic" kidney rather than having the patient remain with one nephrosclerotic kidney is the rationale for the change in procedure. We believe renal artery stenosis as a cause of hypertension is much commoner than is now believed.

The selection of the appropriate case is somewhat difficult, but properly conducted differential renal excretion studies, the response to tetraethylammonium chloride, and, particularly, good renal arteriograms should allow proper selection.

Revascularization should be accomplished by autogenous arteries, the splenic being the best. End-to-side anastomosis is preferred to end-to-end, thus ensuring an addition to the already existing renal blood flow.—Josephus C. Luke, M. D., and B. A. Levitan, M. D., Montreal: *A. M. A. Arch. Surgery*, 79:269, August, 1959.



MATERNAL HEALTH IN OHIO

HEREWITH, your Committee on Maternal Health proudly presents its second annual report. This report consists of three portions, the first being a brief outline of the committee's activities since its initial report to The Council on September 14, 1958; the second giving a statistical summary of the Ohio* Maternal Mortality Study for 1956, and the third presenting recommendations based upon experience gained from the study.

The statistics compiled herein are published in compliance with a House of Delegates directive adopted April 23, 1953, creating this committee; and follow-up action taken by The Council on January 16, 1954.¹

Activities

The prescribed functions of the Committee on Maternal Health were published last year in the (initial) report for 1955.²

Since September, 1958, the committee has held five meetings. Two members have moved from Ohio, one died, and two new members currently bring the committee strength to 20. In the five meetings 101 *maternal cases* were carefully studied and classified on an anonymous basis, using "Guiding Principles for Obstetric Care"³ as a standard. From these cases, selected *maternal death summaries* were published each month in the "Maternal Health in Ohio" column, of *The Ohio State Medical Journal*.*

A medical exhibit depicting statistical findings from the Ohio study, prepared by the committee, was displayed in conjunction with the Franklin County Maternal Mortality exhibit at the OSMA meeting April 21-24. There it received a Certificate of Merit Award. Later it was on display at the Ohio Academy of General Practice meeting September 16-17, 1959, in Columbus. Members of the committee personally attended the exhibit during its display.

In cooperation with the American College of Obstetricians and Gynecologists, District V, the committee conducted an extensive anonymous poll of hospitals in Ohio, to ascertain current methods and practices employed in Obstetrical Anesthesia,

TOPIC THIS MONTH:

Maternal Mortality Report For Ohio—1956

with the view of studying problems to improve the services.

Constantly, members of the committee work to prepare and improve "speakers packets" on various subjects pertaining to maternal deaths. These packets containing data in outline form and visual aids, are available to local medical groups in the state, for educational purposes.

Throughout the year, the committee has acted as an advisory body to The Council, and other committees, on matters pertaining to Maternal Health in Ohio.

In general, terminology used in the Ohio Maternal Mortality Study conforms to international standards, for purposes of uniformity. Additional nomenclature employed herein has been published previously.^{1, 2}

Statistics for 1956 are presented concisely and systematically so as to provide an easy comparison with similar documents in the past, as well as the future.

Ohio Maternal Mortality Study Statistics for 1956

Total live births in Ohio, 1956	234,517
Total cases studied	101
Cases not studied due to lack of information	1
Cases not studied due to lack of investigation and return	18
Maternal Deaths (classified)	85
White	63
Non-white	19
Not Known	3

(Continued on Next Page)

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by official representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

Age:	
Teens	5
20's	40
30's	31
40's	9
Parity:	
Primigravidae	15
Multiparae	64
Unknown	6
Place of death:	
Hospital	78
Other	7
Method of Delivery:	
Operative	31
Non-operative (spontaneous)	23
Not delivered	31
Route of delivery:	
Vaginal	47
Cesarean: (ante mortem)	7
(postmortem delivery)	8
Case classification: (when death occurred)	
Group I (fr. concept. to 20th wk.)	10
Group II (fr. 20th up to 28th wk.)	0
Group III (fr. 28th wk. through term)	15
Group IV (postabortal, postpartum)	60
Autopsies	57
(Coroners cases, 3)	
Classification of preventability:	
Non-preventable	40
Preventable	45
Patient Responsibility (P ₁)	14
Personnel Responsibility (P ₂)	24
Both (P ₁ and P ₂)	7
Prenatal Care (Apparent from data sheets)	
Adequate	40
Inadequate	12
None	11
Excluded ectopic preg. and abortion)	2
Not reported	20

Classification of Primary Causes of Death:

Hemorrhage	26
Abortion	1
Afibrinogenemia	9
Abruptio	4
Am. fl. emb.	3
Dead fetus	2
Ectopic pregnancy	7
Placenta Praevia	2
Postpartum (atony, etc.)	3
Ruptured uterus	4
Infection	11
Abortion, septic (including alleged "criminal abortion")	5
Other: Peritonitis	2
Septicemia	3
Up. Resp. Inf.	1
Toxemia	15
Chronic Hypertension (including hypertension with cereb:ovascular accident)	7
Eclampsia	7
Preeclampsia	1
Other	33
Amniotic fluid embolus (no hemorrhage)	2
Anesthesia (General)	2
(Regional)	3
Cardiac disease	10
Cerebrovascular accident (with hypertension)	3
Liver diseases	1
Lower nephron nephrosis	3
Pulmonary embolus	9

In Ohio, there were 234,517 live births reported for the year 1956. From this study, classi-

fying 85 maternal deaths for the year, the maternal mortality rate was 0.36 per 1,000 live births, or 3.62 per 10,000 live births.

Discussion

As in the past, the Committee reviewed every case conscientiously, studying the facts and data. Final classification of each case was made entirely upon available information. This was adequate in most cases, but in others it was extremely meager. Preventability (avoidability) in each case was determined, using "Guiding Principles for Obstetric Care"³ as a standard.

Of the 121 cases located for the project during 1956, 19 could not be studied due to the lack of information. Inability to complete the necessary data at local levels rendered the cases useless! Seven of these were cases occurring in one city. Committee members in this area have taken steps to remedy the situation.

The greatest majority of deaths in the parity group (64) occurred among multiparae. During 1956, there were only 31 operative deliveries (compared to 52 in 1955); only eight cesarean sections (ante mortem) were performed in this group. The number of cases submitted to autopsy examination was only 57 in a possible 85. In studying cases occurring during 1956, the Committee regretted that a lack of autopsy findings in many instances prevented an accurate evaluation of facts which were available.

Of 85 maternal deaths, 52.9 per cent were voted preventable on the basis of information submitted.

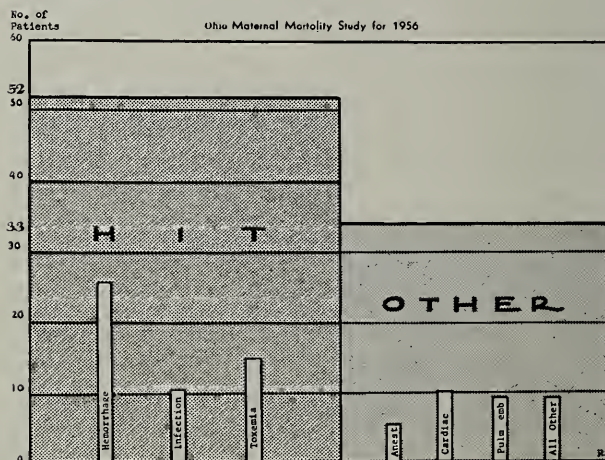


FIG. 1. Classification of primary causes of death; 85 maternal deaths, 1956.

Hemorrhage leads as a primary single cause of death with 26 cases (30.6 per cent); 9 of these cases involved afibrinogenemia! Toxemia caused 15 deaths (17.6 per cent), a rise of 6 cases over the 1955 figure.

"Other Causes" accounted for 33 deaths of the 85 cases, the greatest, 10 deaths, being placed

under cardiac disease. Anesthetic deaths reported accounted for 5 deaths, compared to 14 in 1955. Closest to cardiac disease, pulmonary embolus caused 9 deaths, the next in numerical order.

The Committee feels that a number of cases may have escaped inclusion in the 1956 study due to errors in affixing the full diagnosis on death certificates⁴; it must be remembered that the majority of cases are located through death certificates filed in the Bureau of Vital Statistics.

Recommendations

1. The Committee recommends that this project with its various phases be continued with increased vigor, to reduce further the maternal mortality and morbidity in Ohio.

2. It is recommended also that The Council members continue to convey interest and support for this project to their various districts, encouraging physicians and their personnel to keep more accurate records on patients.

3. Since hemorrhage and toxemia appear to lead the single causes of death, pre-natal care should be improved. Only 40 of the 85 cases which the Committee voted "maternal" were known to have *adequate* pre-natal care.

4. Local maternal mortality studies should be encouraged. The Committee has revised the questionnaire form for collecting data on each case, and is distributing copies to various area study groups on request. This action should result in a uniform state-wide system for collection and tabulation of information, and will assist them in furnishing data for the State Study.

The Chairman takes this opportunity to express appreciation to members of the Committee who have discharged their duties faithfully and conscientiously during the past year. Furthermore, the Committee acknowledges with gratitude the cooperation afforded by attending physicians, representatives of the various County Medical Societies, the Ohio Department of Health, and other organizations. Without their untiring assistance this study would have been incomplete.

Respectfully submitted,

ANTHONY RUPPERSBERG, JR., M. D., *Chairman, Committee on Maternal Health.*

Approved by The Council of the Ohio State Medical Association, September 20, 1959.

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Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEPFEL, M. D.
Columbus, Ohio, Chairman

Following is the summary of a case which was discussed before the Franklin County Pelvic Cancer Delay Committee on October 21, 1959, at its regular monthly meeting held at the University Health Center.

Case No: 74. The patient is a 53 year old white woman who first noticed the onset of abdominal enlargement one year prior to admission. She was seen by her family physician who recommended that she have consultation because of a pelvic mass. The patient did not report for additional examination until four months prior to admission. At this time she started daily bleeding and continued to bleed until the time that she was admitted to the University Hospital. Her initial hemoglobin was 4.8 grams.

The patient was given transfusion daily with 1000 cc. of whole blood or packed cells. In spite of vigorous transfusion the hemoglobin could be carried only to an 8.4 gram level. A dilatation and curettage was carried out on the sixth hospital day and a diagnosis of mixed mesodermal sarcoma of the uterus was made. The tumor mass increased in the six day hospital stay from 20 centimeters above the level of the symphysis to 25 centimeters. Following a dilatation and curettage the patient was returned to surgery and a total hysterectomy bilateral salpingo-oophorectomy with gland dissection was carried out.

Comments

DR. POMEROY: Therapy in cases of sarcoma of the uterus is generally confined to the surgical approach. Preliminary irradiation may be of some value when it is possible to irradiate a relatively small area. Tumor mass such as that described here could only be treated palliatively.

DR. OLDS: This tumor is particularly malignant and early spreads via the hematogenous route. It is a relatively rare tumor and the survivorship is less than 10 per cent.

DR. BOUTSELIS: The cures in these individuals is dependent upon early diagnosis—one might almost say by chance diagnosis during routine pelvic examination, or diagnosis associated with other pelvic surgery.

DR. HOLZAEPFEL: Patient delay in this case must be the major factor and one could state that there is a 12 month patient delay. The medical profession, however, must assume some responsibility of careful follow-up in patients in whom a malignant lesion is suspected. We feel that with the possibility of malignancy present the physician should have some flag system. He should have the fact continually brought to his attention that this patient is undiagnosed and untreated. We recommend some chart or file system in each office so that the physician could be constantly alerted that as yet this patient has had no definite diagnosis or treatment.

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•Hirsch, H. A., and Finland, M.
New England J. Med. 260: 1151
(May 28) 1959

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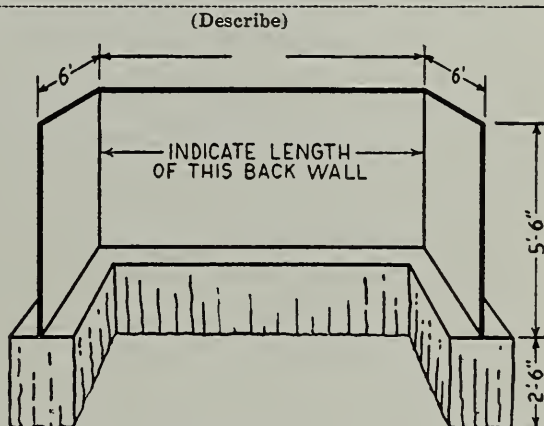
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Booths will have a back wall and two side walls. The side walls of all booths will be six feet wide. Back wall and side walls are eight feet high. If standard shelf is used, only 5½ ft. will be available for exhibit material. For most exhibits, a back wall, eight feet long will be sufficient. With the two 6 ft. long side walls, this gives a total of 110 square feet of wall space.

Ruling on Immunizations . . .

Attorney General States New State Law Only A Minimum Standard; Holds that Local Areas Can Make and Enforce Their Own Regulations

THE authority of local boards of education to make and enforce their own regulations regarding vaccination or immunization of pupils, a power which they already had under Section 3313.67 of the Revised Code, is preserved and continues under the new state immunization law adopted by the 103rd Ohio General Assembly.

This is the ruling of Ohio Attorney General Mark McElroy in Opinion No. 890, issued October 23, 1959.

State Law A Minimum Requirement

The opinion advises that the new immunization law (Am. House Bill 323) specifically authorizes local school districts to continue to make and enforce such rules and regulations, and that the newly created section of the Revised Code, Section 3313.671, has not preempted for the State the field of requiring vaccination or immunization, but has only promulgated a minimum requirement.

Opinion No. 890 was issued in answer to a request from the Hon. G. William Brokaw, prosecuting attorney for Columbiana County, who explained that all school districts in that county have been for several years requiring the vaccinations and immunizations now required in the state law, with the exception of polio.

Question of Exemptions Arises

"These school regulations do not contain a right of objection by the parent or guardian, except where the pupil may be allergic to certain vaccines," Mr. Brokaw stated.

In the light of this conflict with the state law, which exempts the student from compliance upon presentation of a written statement of his parent or guardian, objecting to the immunizations, prosecuting Attorney Brokaw asked for the interpretation of this specific question:

"Must a school district which has a regulation requiring immunizations, and not allowing for objections by parents or guardians, honor any objections to these immunizations which may be presented to them by pupils before beginning school this fall?"

Can Keep Own Rulings on Exemptions

The Attorney General advised in reply that as the Columbiana County school districts were presumably requiring vaccinations and immunizations under the authority of Section 3313.67, Revised

Code, "the authority to continue these requirements under whatever rules or regulations the local districts see fit to adopt has been specifically preserved by the General Assembly."

Leading up to this statement the Attorney General quoted Section 3313.671, Revised Code, a part of Amended House Bill 323, and commented as follows:

"It will be noted that the new section preserves the right of a local board 'to make and enforce rules or regulations to secure vaccination or immunization against poliomyelitis, smallpox, diphtheria, pertussis, and tetanus of the pupils under its jurisdictions.' This language is almost identical with the permissive language of Section 3313.67, Revised Code.

"If this passage were not part of the new act, the question of preemption of the field by the General Assembly would have been squarely raised. But, as the General Assembly saw fit to retain the regulatory powers of the local school districts by insertion in the new enactment of almost the exact language contained in the older statute, it may safely be presumed that the Legislature intended to leave local vaccination enforcement, in those districts where it existed, unaffected by the new act except for the minimum requirement of vaccination or immunization.

"This view is further supported by the fact that Section 3313.67, Revised Code, was not repealed and, therefore, the authorization to adopt local rules or regulations still exists and is, in fact, the same authorization which existed prior to the passage of Amended House Bill 323 . . ."

Old Law "Not Amended or Repealed"

Mr. McElroy's concluding paragraph reads as follows:

"It is, therefore, my opinion and you are accordingly advised that the General Assembly, under newly enacted Section 3313.671, Revised Code, has not preempted the field of requiring vaccination or immunization for school pupils but has only promulgated a minimum requirement while specifically authorizing local school districts to continue to make and enforce rules or regulations to secure vaccination or immunization of their pupils, a power which local school districts already had under the provisions of Section 3313.67, Revised Code, which section has not been amended or repealed."

WARNING TO ALL MEMBERS!

- ★ Your Memberships in the Ohio State Medical Association and American Medical Association, Including Subscriptions to *The Ohio State Medical Journal* and *The Journal of the AMA*, Will expire on December 31. Here's How To Renew Them:
- ★ It's time for all members to pay 1960 membership dues — local, state and national — unless in an exempt classification.
- ★ Mail your check immediately for dues to the **SECRETARY-TREASURER of YOUR COUNTY MEDICAL SOCIETY.**
- ★ OSMA dues are \$30.00. AMA membership dues are \$25.00. If you don't know the amount of your County Medical Society dues, check with your local Secretary-Treasurer.
- ★ Many members probably will want to send one check to cover local, state and national dues. **Make Check Payable To Your County Medical Society.** If you do tender a separate check for AMA dues, make it payable to your County Medical Society and mark on the check the words "For 1960 AMA dues."
- ★ Your local Secretary-Treasurer will forward state and national dues for you and other members to the Columbus Office of the OSMA. That office will transmit AMA dues to Chicago.
- ★ **Remember:** As a part of the privileges and services offered to all members of the OSMA, you will receive a year's subscription to *The Ohio State Medical Journal*, without extra cost. Dues-paying members of the AMA will receive a year's subscription to *The Journal of the AMA*, *Today's Health*, *The AMA News*, and an *AMA Specialty Journal* of choice.
- ★ Memberships and subscriptions are on a calendar year basis. Both expire on December 31. Renewal must be made by January 1, 1960, to keep them current.
- ★ Members who were exempt from paying OSMA or AMA dues, or both, in 1959 will be carried over automatically on the 1960 membership roster of both organizations unless their status has changed.

Tax Roundup for Physicians . . .

Here Are Pointers for Doctors and Summaries of State and Federal Tax Laws Under which Most Physicians Make Periodic Returns and Payments

DURING the early part of 1960 physicians will again face the task of filing returns and making payments under several categories of Federal, State and local tax laws. This article is presented for the purpose of furnishing at least basic information on the following taxes with which most Ohio physicians are confronted.

(1) Federal Income Tax Law, including payroll withholding on employees' salaries.

(2) Federal Social Security Tax including Old Age and Survivors' Insurance tax and the Federal and State Unemployment Insurance taxes.

(3) Ohio Personal Property Tax, including the tax on tangible property used in business and the tax on intangible personal property such as stocks, bonds, investments, cash and accounts receivable.

(4) Ohio Workmen's Compensation tax, required of those with three or more employees (optional for those with one or two).

(5) Ohio Sales and Use Tax.

(6) City Payroll Tax, applying to residents of cities which have such tax.

Information in this article is confined to those taxes on which the taxpayer or employer must file periodic returns. It does not include reviews of such taxes as those on real property, for which the taxpayer is billed directly, nor does it include discussion of many excise taxes for which the vendor of goods or services is primarily responsible; neither does it include a discussion of licenses.

The data and advice presented were obtained from authentic tax publications and from personal interviews with tax officials.

Nevertheless, physicians are advised to obtain supplemental advice and assistance in the preparation of their returns, from competent tax authorities or from staff members of the office of the District Directors of Internal Revenue or other appropriate agency. A tax expert may point the way to substantial savings as well as steer the taxpayer around embarrassing errors.

FEDERAL INCOME TAX

Taxpayers will pay 1959 Federal Income Taxes under provisions of the Revenue Code of 1954. Computation of this year's tax will be similar to that of the last four years since there have been no basic changes in procedure.

Forms and Payments

Every person under 65 years old whose gross income for the year was \$600 or more, and every person 65 years old or older whose gross income

was \$1,200 or more, must file certain income tax returns with the District Director of Internal Revenue for his district not later than April 15, 1960.

There are four types of returns, Form 1040A, Short-Form 1040, Long-Form 1040 and Form 1040W.

Form 1040A may be used if the income was less than \$10,000 and consisted entirely of wages reported on Withholding Statements, or such wages and not more than \$200 total of other wages, interest and dividends (excluding \$50 of dividends). When this form is used, if the income was under \$5,000, the Internal Revenue Service will figure the tax and send the taxpayer a bill or refund. If the income was \$5,000 or more, the taxpayer must compute his own tax.

Short-Form 1040 is used if the income is less than \$10,000 and the taxpayer must include income from sources not eligible for reporting on Form 1040A; wishes to deduct from wages certain reimbursed expenses, travel, transportation, etc.; or the taxpayer wishes to deduct credits for dividends and retirement income.

Long-Form 1040 must be used if the income was \$10,000 or more, or if the taxpayer wishes to claim nonbusiness deductions that amount to more than 10 per cent of income.

Form 1040W is a new streamlined optional two-page Form 1040. It can be used by a taxpayer whose income consists of (1) salary and wages subject to withholdings regardless of amount, (2) not more than \$200 in dividends and interest, and (3) no other items of income.

Income-Splitting

Many physicians will find it to their advantage to file joint returns with their wives, whether or not the spouse has income of her own. An unmarried person who qualifies as "head of household" may claim about one-half the tax benefit afforded a married couple on a joint return.

Declaration of Estimated Tax

The provisions for filing declarations of estimated income taxes are principally for those per-

sons, a substantial part of whose income is not subject to withholdings.

When filing a final return for 1959, on or before April 15, 1960, most physicians will be required to file an estimate of 1960 income.

If income from items other than wages is \$100 or less, declarations are required if the gross income from wages subject to withholdings can reasonably be expected to exceed \$5,000 in the case of a single person; or \$10,000 in the case of a married couple, head of a household or surviving spouse.

If income other than wages subject to withholdings can reasonably be expected to exceed \$100 (excluding \$50 from dividends), a declaration is required if total income including wages subject to withholdings can reasonably be expected to exceed \$600 multiplied by the number of exemptions that could be claimed on the taxpayer's return, plus \$400.

Times to file declarations of estimated tax by individuals is April 15 (or at time final return is made), June 15, September 15 and January 15. The date for filing an income tax return in lieu of a final declaration of estimated tax is January 31. Thus, if an income tax return is not filed before February 1, the last day for filing declaration or an amended declaration is January 15.

If the estimated tax paid is 70 per cent or more of the actual tax liability, no penalty is assessed. For physicians who find it difficult to estimate their income in advance, it is suggested that they use the previous year's income as a basis and later file an amended declaration if the situation changes considerably.

Physicians in Private Practice

To summarize, most physicians in private practice must comply with the following procedures:

1. On or before January 15, 1960, make a fourth quarter return on declaration of estimated income for 1959.
2. On or before April 15, file a complete income tax return for 1959.
3. Pay the difference, if any, between the income tax paid quarterly and the amount of tax liability shown on the final return. If he has overpaid, the excess will be refunded or credited against future payments.
4. On or before April 15, file a declaration of estimated tax liability for 1960, and pay either the full amount or one-fourth of it. If he elects to pay quarterly, the remaining final dates for

payment are June 15, September 15 (and January 15, 1961).

Adjusted Gross Income

Individuals who are employed and receive a salary have little difficulty in arriving at the amount of their adjusted gross income. The total salary received plus amounts received from interest, dividends, rent, or from other sources, would in such cases constitute the gross adjusted income.

The physician in private practice has more difficulty in arriving at his adjusted gross income than the person on salary. From the amount of his cash receipts—if he reports income on the basis of cash received and disbursements, or on the amount of total charges if he uses accrual method of reporting his income—he may deduct all items of expenditure necessary in earning his income. These items are described in more detail in the following sections:

Deductible Business Expenses

Office Rental—If a physician pays rent to another person for office space, he may deduct such amount. If he rents a combined home and office, he may deduct that portion of the rent charged for the office. If he owns his own home and maintains an office in it, he cannot claim deduction for office rent. However, he is entitled to claim depreciation on that portion of the property occupied as an office, and the proportion of operating expenses chargeable to the office.

Automobile—The cost of repair and upkeep of an automobile, including gasoline and oil, used in professional visits may be deducted. That part of the salary paid to a chauffeur and attributable to time spent in driving his employer on professional calls, may be deducted. Sums spent for taxi, hire, bus, etc., while on professional calls, may be deducted.

Depreciation may be deducted on an automobile used in professional business. The depreciation which should be deducted annually is determined by dividing the cost price of the machine, less salvage value, by the number of years of its usefulness. Salvage value is the estimated amount that will be realized upon sale or disposition of the automobile at the end of its useful life—the useful life varying according to the policy of the taxpayer.

If a physician has one automobile which is used exclusively in professional business, he may deduct the full depreciation each year. If the machine is used only partly in professional business, the deductible depreciation should be computed on the basis of the number of miles the car is driven for professional purposes. If a physician possesses two cars, each of which is used

partly in professional business the deductible depreciation on each car should be computed on the basis of the number of miles each car is driven for professional purposes.

The physician should seek the advice of a tax expert as to whether or not application of the "declining-balance method" (explained in the instructions which accompany the tax forms) would be advantageous to him.

A loss occasioned by damage to an automobile maintained either for business or pleasure, which is not due to the willful act or negligence of the taxpayer, is deductible loss in the computation of net income, provided the taxpayer has not been reimbursed for such loss by insurance.

It is suggested that physicians be prepared to substantiate claims for deductions from gross income for professional use of automobiles in case income tax officials should call on them for written records to show the mileage traveled by them in connection with professional practice, or to prove just what part of their automobile maintenance expense was a professional expense, and therefore deductible.

Professional Dues—Dues paid to professional associations to which, in the interest of his profession, the physician belongs, may be deducted.

Refresher Courses—The Internal Revenue Service makes a distinction between expenses for advanced education and those for refresher courses (Sec. 1.162-5 of the Internal Revenue Service regulations).

The regulation provides that expenditures for education are deductible if they are for "refresher" or similar types of courses taken to maintain the skills directly and immediately required by the physician in his employment or practice. An educational course to be covered should be designed for established medical practitioners to help them keep abreast of current developments in the profession; it should be of short duration; it should not be taken on a continuing basis, and should not carry academic credit.

Cost of education designed to prepare the practitioner to enter a specialty is not deductible.

Travel Expenses—When a physician travels away from home primarily to obtain "refresher" education or to attend a medical convention for professional purposes, his expenditures for travel, meals, lodging, etc., are deductible. However, expenses for personal activities such as sight-seeing, social visiting, personal entertaining or other recreation, are not deductible. A physician who is accompanied by his wife to a medical convention may deduct the amount that the trip would have cost him alone. For example, if he and his wife

have a double room, he may deduct the amount that he would have paid for a single room.

Salaries and Wages—Deductions are permitted for the salaries or wages of nurses, laboratory workers, technicians, assistants, stenographers, or other clerical workers in a physician's office so long as their duties are connected with professional work; also for wages paid maids, janitors, etc., for services rendered in connection with professional practice.

Medicine, Supplies, Etc.—Cost of medicines used in the office to treat patients, medicine dispensed, bandages, laboratory materials, chemicals and other supplies "consumed in the using" and necessary to operate the office may be deducted.

Depreciation—Depreciation may be claimed on instruments, laboratory equipment, office furniture, books, etc., of more or less permanent value, the rate of depreciation depending on the estimated useful life of the article. The "declining-balance" method of depreciation permits the taxpayer to charge off a larger proportion of the cost of equipment during its early life, under certain conditions.

If improvements to offset obsolescence and wear and tear or injury has been made and deduction for the cost claimed elsewhere in the return, claim should not be made for depreciation.

Uniforms—The Internal Revenue Service permits deduction of the cost of medical uniforms (garments, etc., necessary in practice but not suitable for street wear) as business expense.

General Office Expenses—The cost of telephone, telegrams, heat, light, water, etc., used in professional services is deductible. Physicians who keep current magazines and newspapers in their waiting rooms for the benefit of their patients, may deduct this item as a business expense. The cost of professional journals for the physician's own use is also a deductible item.

Debts—If the physician's books are kept according to the "Cash Receipts and Disbursements" system, he may not charge off any unpaid debt because he is then only reporting as gross income those accounts which have proved to be good. Bad accounts have not been reported and are therefore not deductible.

If books are kept on an "Accrual Basis" (i. e., all fees, either cash or account are included in income reported for tax purpose) it is permissible to charge off all debts which have been definitely ascertained to be worthless during the fiscal year covered by the report.

The physician using the latter system must be careful to include in gross income bad debts which have been charged off in previous years but col-

lected during the calendar year for which the return is filed.

Taxes and Licenses—State and county taxes, except those assessed against local benefits of a kind tending to increase the value of the property assessed and those imposed upon the taxpayer for his interest as shareholder of a corporation which are paid by the corporation without reimbursement from the taxpayer, are deductible. Taxes on one's own home are not to be considered as business expenses, such taxes being allowable as nonbusiness deductions only.

Fees and expenses paid for "securing the right to practice" are not deductible, such as the fee paid to secure a license from the State Medical Board. Other license fees which the physician must pay, including narcotics registration and local occupational taxes, are deductible. The cost of an automobile license, unless the car is used exclusively for business, is to be taken as a nonbusiness deduction only. The tax paid on telephone bills if the telephone is used for business only, is deductible as a business expense. This would apply to office phones. The tax paid on other telephone bills is not deductible. Federal taxes on amusements, club dues, furs and luxuries are also not deductible for Federal income tax purposes.

Federal Old Age Benefits and Unemployment Compensation Taxes paid by employers under the Social Security Act are proper deductions in making income tax returns. Such taxes are deductible in returns for the taxable year in which they are accrued or paid, depending upon the method of accounting employed by the taxpayer. Social Security taxes withheld by an employer are not deductible by the employee in computing his tax liability.

Insurance Premiums—Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries to a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment and damage to or loss of professional equipment by fire or otherwise. Premiums paid on life insurance are not deductible.

The United States Tax Court in a case decided in June, 1957, held that premiums paid by a doctor for disability insurance are **non-deductible** personal expenses, even where the policy is called a "Professional Income Policy." In the case before the court, there were no provisions in the insurance policies specifying that payments thereunder during disability were to defray or reimburse the holder for business or overhead ex-

penses. Specific provision must be set forth in any policies of this type that the amounts will be for business or overhead expense in order to make the premiums deductible.

Sales Tax Payments—The sales tax paid in connection with purchase of items used in business become a part of the cost thereof and as such are deductible as business expenses. Other amounts expended for sales tax are nonbusiness deductions and not to be taken as business expenses.

Ohio and Federal Gasoline Taxes—The Ohio tax on gasoline was increased from five cents to seven cents per gallon on May 31, 1959. The Federal tax on gasoline was increased from three to four cents per gallon on October 1, 1959. These amounts are deductible during the periods effective. However, if a physician has already included overall cost of gasoline as part of his business expenses, the tax is not again deductible. The Ohio tax paid on gasoline not used in business is deductible as a nonbusiness deduction. The Federal tax is deductible only as a business expense.

Interest—Amounts paid as interest on business indebtedness may be taken as business expenses. Interest items paid on personal indebtedness are deductible only as nonbusiness deductions. Interest paid to carry tax free securities may not be deducted. The interest deduction may not exceed the portion of the total carrying charges attributable to the taxable year.

Carrying charges on installment purchases up to 6 per cent of unpaid balances are deductible where the taxpayer has carrying charge separately stated in installment sales contract.

Losses by Fire and Theft—Loss or damage to a physician's equipment by fire, theft, or other cause, not compensable by insurance or otherwise recoverable, may be computed as a business expense, and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent to which it has not been made good by repair, and the cost of the repair is claimed as a deduction.

Legal Expenses—Expense incurred in the defense of a suit for alleged malpractice is deductible as business expense. However, expense incurred in the defense of a criminal action is not deductible. The cost of contesting tax liabilities is deductible.

Entertainment Expenses

Following are excerpts from a communication sent to a medical society in Mississippi by a District Director of Internal Revenue which the Law Department of the AMA says was one of the best

explanations regarding deduction of physician's entertainment expenses it has seen:

1. A physician may deduct on his federal income tax return the costs of entertainment, provided he can establish to the satisfaction of the Internal Revenue Service, by appropriate evidence, that such expenses are ordinary and necessary business expenses and clearly related to the production of business income.

2. The amount of the deduction must be proved and its reasonableness determined. Once the amount is established, the deduction may be claimed when the doctor is able to show that the entertainment had a direct relationship to the conduct of his practice and can show the business benefit reasonably to be expected from the expenditure. The general statement that he hoped or expected to get referrals or patients as a result of the entertainments is not enough. If personal reasons predominate, the expenditure may not be deducted, even though there is some possibility of a business benefit. Except in the case of industrial physicians, entertainment of individuals who are not doctors will not ordinarily qualify because the possibility of benefits to be expected is so remote as to be negligible. In instances of the entertainment of patients, the same general rules apply as in the entertainment of other doctors, and the clear relationship of the expenditure to reasonably expected income must be shown. The same rules also apply to civic and other club dues.

Criteria to be used in establishing the deductibility of entertainment expenses include, but are not limited to, the following:

- a. Specific purpose of entertainment.
- b. Nature of the practice of the doctor incurring the expenditure.
- c. Period of time the doctor has been in practice and the number of patients he already has.
- d. Percentage of his patients received as referrals.
- e. Names of individuals entertained and reason why additional income could reasonably be expected from each.
- f. Whether or not referrals were actually received from the doctors entertained and any indication of the effect of the entertainment on these referrals.
- g. Number of times individual doctors were entertained during the year, inasmuch as repeated entertainment indicates a personal motive.
- h. Whether or not other doctors in the same type practice in the locality have entertainment expenses.

Exemptions and Allowances

An exemption of \$600 may be claimed by the taxpayer for himself. He may also claim an exemption of \$600 for each dependent of close relationship, or for certain other dependents living in his household. To claim an exemption for a

dependent, the taxpayer must have furnished over half of the actual amount used for the dependent's support in the taxable year. Scholarships do not count as income to the child in determining the extent of parental support.

Exemption also is contingent upon the dependent, other than a child, having a net income of less than \$600 for the year. A child may earn \$600 or more and still qualify as a dependent if he is under 19 or a full-time student for five months during the year, or taking on-the-farm training, provided the taxpayer contributes more than half of his support.

An additional personal exemption of \$600 may be claimed by the taxpayer if he is over 65, another if he is blind; another if his spouse is blind; and still another if the spouse has reached the age of 65. (These provisions do not apply to dependents other than spouse.)

Nonbusiness Deductions

Regardless of whether or not the taxpayer claims business expenses, he may claim the following deductions if eligible to do so, **providing that there is not a duplication of deductions under the two categories.**

Contributions, Gifts, etc.—The individual taxpayer may deduct contributions up to 30 per cent of adjusted gross income, if the last 10 per cent is given to a church, an association of churches, an educational institution or a hospital. The ceiling remains at 20 per cent for contributions to other charitable organizations, no substantial part of the activities of which are carrying on propaganda or otherwise attempting to influence legislation.

Medical and Dental Expenses—The taxpayer may deduct medical and dental expenses which exceed 3 per cent of the adjusted gross income. However, in figuring these expenses, the amount paid for medicine and drugs may be taken into account only to the extent it exceeds 1 per cent of the adjusted gross income.

The deduction may not exceed \$2,500 multiplied by the number of exemptions other than the exemptions for age and blindness. In addition there are maximum limitations as follows: (a) \$5,000 if the taxpayer is single and not a head of household or a qualifying surviving widow or widower; (b) \$5,000 if the taxpayer is married but files a separate return; or (c) \$10,000 if the taxpayer files a joint return, or is a head of household or a qualifying surviving widow or widower.

If the taxpayer or his wife is 65 or over, the maximum limitations are the same as in the foregoing paragraph. However, amounts deductible for medical and dental expenses are not restricted to the excess over 3 per cent of adjusted gross in-

come. In effect, the 3 per cent rule may be disregarded. But the amounts spent for medicine and drugs are still limited to the excess of 1 per cent of income, and amounts spent for dependents' medical expenses are deductible only to the extent they exceed 3 per cent of adjusted gross income.

Medical expenses paid by an estate within one year after death are considered paid by the decedent.

The term "medical care" is broadly defined to include "amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body (including amounts paid for accident or health insurances)."

In regard to payment of premiums on accident and health insurance, the Internal Revenue Service has ruled that premiums may be deducted for insurance that provides for indemnity for the cost of medical care and specific injury, but may not be deducted for insurance which indemnifies the holder solely for the loss of earnings.

In order to obtain this credit for medical and dental expenses, the taxpayer is required to list the name and address of the person to whom the payment is made, the approximate date of actual payment and amount. It should be noted that this will furnish the Internal Revenue Service with data which can be used in checking returns filed by physicians and dentists—another reason why they should keep accurate records and compile their returns carefully.

Interest—The taxpayer may deduct interest on a personal note to a bank or individual, a mortgage on his home, a life insurance loan if the interest is paid in cash, or interest on delinquent taxes.

Taxes—Deduction may be made for taxes paid on personal property or real estate, for city income taxes, retail sales taxes, auto license fees, state gasoline taxes.

Casualty Losses and Thefts—The taxpayer may deduct losses due to destruction of property by fire, stolen property or cash, and storm damage, if not claimed as a business deduction and not covered by insurance.

Optional Standard Deduction

The optional standard deduction permitted in lieu of listing amounts paid for contributions, interest, taxes, and other nonbusiness deductions is 10 per cent of the adjusted gross income, but not in excess of \$1,000; or \$500 in the case of a married person filing a separate return.

Partnerships

The partnership itself is not subject to income tax, but is required to file an information return.

The tax liability falls upon the individual partners. Partnerships may be simple agreements by which two or more physicians share expenses and prorate income. On the other hand, they may be elaborate entities. Since there are many special regulations pertaining to partnerships, partners would do well to seek expert advice.

Retirement Income

Retirement income, including pensions, annuities, interest, rents, dividends, etc., are subject to special treatment under the income tax laws.

District Offices and Districts

Income tax payments and returns must be made at or mailed to the office of the District Director of Internal Revenue for the district in which the taxpayer has his legal residence. There are four internal revenue districts in Ohio. The counties comprising each district follow:

For the Columbus District (Ohio 11th) Director of Internal Revenue, 110 W. Long St., Columbus; comprising the following counties:

Adams, Athens, Coshocton, Delaware, Fairfield, Franklin, Gallia, Guernsey, Hocking, Jackson, Knox, Lawrence, Licking, Madison, Marion, Meigs, Morgan, Morrow, Muskingum, Noble, Perry, Pickaway, Pike, Ross, Scioto, Union, Vinton and Washington.

For the Cleveland District (Ohio 18th) Director of Internal Revenue, 626 Huron Rd., Cleveland; comprising the following counties:

Ashland, Ashtabula, Belmont, Carroll, Columbiana, Cuyahoga, Geauga, Harrison, Holmes, Jefferson, Lake, Lorain, Mahoning, Medina, Monroe, Portage, Richland, Stark, Summit, Trumbull, Tuscarawas and Wayne.

For the Cincinnati District (Ohio 1st) Director of Internal Revenue, Post Office Building, Cincinnati; comprising the following counties:

Brown, Butler, Clark, Clermont, Clinton, Fayette, Greene, Hamilton, Highland, Miami, Montgomery, Preble and Warren.

For the Toledo District (Ohio 10th) Director of Internal Revenue, Toledo; comprising the following counties:

Allen, Auglaize, Champaign, Crawford, Drake, Defiance, Erie, Fulton, Hancock, Hardin, Henry, Huron, Logan, Lucas, Mercer, Ottawa, Paulding, Putnam, Sandusky, Seneca, Shelby, Van Wert, Williams, Wood and Wyandot.

INCOME TAX WITHHOLDINGS

Every employer who pays wages to one or more employees, where an employer-employee relationship exists, must withhold from such wages and

pay over to the Federal Government periodically an amount prescribed by law.

The amount to be deducted from each pay check may be determined by referring to the *Employer's Tax Guide Circular E* after having the employee fill out Form W-4 to determine the number of exemptions he claims. The handbook is supplied by the District Office of the Director of Internal Revenue.

The amount deducted is paid to the District Office of the Director of Internal Revenue together with report on Form 941T, quarterly during the month immediately following the quarter for which deductions are made. (Social Security taxes are reported on this same form.)

The employer is required to give each employee from whose wages he has withheld income tax during the year a statement in duplicate showing the amount of tax withheld and wages paid for that year. Forms W-2 in quadruplicate are supplied for this purpose. The original copy of Form W-2 is to be filed with the Employer's Quarterly Federal Tax Return, Form 941T, for the last quarter. The second and third copies are furnished the employee and the fourth copy retained by the employer for his records. Statements must be furnished employees and reports made to the government between January 1 and January 31, for the previous year.

Deposit of Withholdings

An employer who withholds as much as \$100 per month for the purposes of income tax liability and F.I.C.A. liability (employer's and employee's shares) shall take these funds with Form 450 to a bank and deposit them. The bank transmits this form to the Federal Reserve Bank in Cleveland for validation, after which it is returned directly to the employer. The depositary receipt, Form 450, is then eligible for use.

Report of Funds Paid

As in previous years, payments in excess of \$600 made during the year for interest, rents, or commissions, not subject to withholdings and paid to anyone other than a corporation, must be reported on Form 1099 and transmitted with Form 1096, on or before February 15 of the following year to the Director of Internal Revenue, Processing Division, Kansas City, Mo.

SOCIAL SECURITY TAXES

The Federal Social Security Act embodies laws pertaining to Old Age and Survivors' Insurance and Unemployment Insurance. Because the procedures for paying these taxes are different, they are discussed here under separate headings.

A person 65 years old or older who is receiving Social Security benefits may earn up to \$1,200 a year without losing his benefit. For any excess earnings over \$1,200 he may lose one month's benefits for each \$80 or fraction thereof. A person 72 or older may earn any amount and continue to draw benefits.

Not covered for social security purposes are services performed by an individual in the employ of his son, daughter, or spouse, and services performed by a child under 21 in the employ of his father or mother.

Under provisions for coverage of self-employed workers, physicians are specifically excluded.

Domestic workers in private homes who receive wages of at least \$50 in a quarter are covered. In other words, if a taxpayer has a cleaning woman, or other domestic worker, only one day a week, she must be covered if she earns \$50 or more in a quarter (approximately \$3.85 per week). Domestic workers in farm homes come under the same provisions as farm workers.

A farm worker who earns \$150 in cash wages during the year must be covered. However, farm workers who perform agricultural services for an employer on 20 or more days during a calendar year for cash at a rate based on some unit of time must be covered regardless of the rate.

Only cash is considered in wages paid to domestic or farm workers, not wages in kind.

Old Age and Survivors' Insurance Tax

The Old Age and Survivors' Insurance Tax is payable by every employer who employs one or more persons in his office or home.

There will be an increase in the amount paid under OASI beginning January 1, 1960. Through December 31, 1959, the employer continues to deduct 2½ per cent on the first \$4800 of the employee's wages and contribute a like amount himself.

Beginning January 1, 1960, the employer will deduct 3 per cent of the employee's wages up to \$4800 and contribute another 3 per cent himself.

The tax return and informational return, combined in one report, is to be filed quarterly. The tax must be paid and the return filed on or before April 30, for the months of January, February and March of that year, in the office of the District Director of Internal Revenue, and quarterly thereafter, payable during the month after the quarter ends.

The employer who hires household help only should file on Form 942, which is in the form of an envelope for convenient mailing. The em-

ployer who reports his office workers on Form 941 may add his domestic workers to this same form.

Farm workers must be reported on Form 943.

Unemployment Tax

Physicians or other employers who have three or more employees, including other physicians, nurses, receptionists, technicians, office workers, etc., are subject to the Ohio Unemployment Compensation Tax. Those who have four or more are liable also for the Federal Unemployment Insurance Tax.

Ohio Unemployment Compensation Tax

In general, employment of three or more persons in any one day including part-time workers renders the employer liable for this tax. A physician who is in doubt as to his liability, should request clarification from the Bureau of Unemployment Compensation, 427 Cleveland Ave., Columbus 16.

Reports are made during the month following each calendar quarter on forms supplied by the Bureau. The tax rate is established for each employer annually. A copy of the calculations made by the Bureau is mailed before the first of the year to each employer. This shows how the rate for the employer for that year was calculated. This rate starts at 2.7 per cent and may be reduced to as low as one-tenth of one per cent. Only the first \$3,000 paid by any employer to any one individual within a calendar year is taxable.

Liable employers should furnish a form BUC-400 to each employee upon separation. These forms may be obtained from the local employment office. If the employee files a claim for benefits, the Bureau will request separation and wage information from the employer. It is imperative that this form requesting separation information be returned to the Bureau within seven days of its receipt.

Federal Unemployment Tax

The Federal Unemployment Insurance Tax applies to employers who have had four or more persons on their payrolls on 20 or more days in the calendar year, each of the 20 days being in different calendar weeks. It is payable to the District Director of Internal Revenue by January 31 for the previous year. The gross tax is three per cent on all individual wages up to \$3,000 and is paid exclusively by the employer—the employee making no contribution. A credit not to exceed 90 per cent of this tax is allowed on all payrolls which were reported to the state unemployment compensation agency (see under Ohio Unemployment Compensation Tax) and the state tax paid by January 31. If an employer has paid his state

unemployment tax in full, the Federal tax is reduced to three-tenths of one per cent.

OHIO WORKMEN'S COMPENSATION

The purpose of the Bureau of Workmen's Compensation is to maintain a Workmen's Compensation Insurance Fund from which to pay compensation to workmen for injury or occupational disease and compensation to dependents for death occasioned in the course of or arising out of employment.

Every employer in the state employing three or more employees regularly in the same business is required to furnish the Bureau of Workmen's Compensation with specified information about employees he has had during the previous year, and to contribute to the State Insurance and Occupational Disease Fund in an amount based on the payroll and at a premium rate based on the class of risk. (The employer under certain circumstances may elect under bond to comply with the provisions of the law by self-insuring the risk.)

Employers of less than three employees may voluntarily subscribe to and obtain insurance in the Fund.

Insurance accounts are adjusted and reports made for the first half and second half of the calendar year. Reports are due with premiums attached by September 1 for the first half of the year, and by March 1 for the second half of the year. Another requirement is an advance permanent deposit based on eight months estimated payroll for the periods January 1 - August 31 and July 1 - February 28, respectively.

The Bureau of Workmen's Compensation comprises 16 regional offices in addition to the central office in Columbus.

OHIO PERSONAL PROPERTY TAX

Returns under the Ohio Personal Property Tax Law must be made between February 15 and April 30 annually. One-half of the amount of the tax is paid when the return is filed, and the other half is due September 20.

It must be kept in mind that tangibles to be listed include personal property used in business, such as a physician's office furniture, fixtures, equipment, supplies (including medicines), etc. Such tangible property should be listed at its book value. A depreciation of 10 per cent annually from cost will be allowed until such equipment reaches a value of 30 per cent. It should stop at that figure for a year. Then such office equipment may be reduced 2½ per cent each year until it reaches a minimum value of 20 per cent, which value should be kept as a utility value.

When a physician opens his practice (or a per-

son starts in business) during the calendar year, he is required by law to list all his taxable property, as of the date he engaged in practice. The valuation of all taxable property to be returned for taxation is determined by multiplying the value by the number of months the taxpayer has been in practice and dividing by 12.

Forms 937 and 902, obtained from the Ohio Department of Taxation, must be filed with the Personal Property Tax return to obtain a lesser value than 20 per cent.

Returns should be filed in duplicate. The so-called tangible tax statutes are intricate and complicated so each physician having taxable personal property for listing should obtain competent advice in case of doubt as to the meaning of any of the provisions of the law.

Accounts receivable are to be listed in accordance with Section 5711.18 of the Revised Code part of which reads, "Claim for any deduction from net book value of accounts receivable or depreciated book value of personal property must be made in writing by the taxpayer at the time of making return," on supplementary tax form 902.

All taxable personal property and credits used in business shall be listed as of the close of business of the last day of December, annually.

As defined in Section 5701.07 R. C., credits "mean the excess of the sum of all current accounts receivable and prepaid items used in business when added together estimating every such account and item at its true value in money, over and above the sum of current accounts payable of the business, other than taxes and assessments."

The same section states that "current accounts include items receivable or payable on demand or within one year from the date of inception, however evidenced."

To arrive at a fair estimate of his current accounts receivable, the physician is advised to note after each account what he considers its value. If he believes the account can be collected in full, it should be listed at its full face value. Otherwise it should be listed at a percentage of its true value, or "no value" if that is the case. The total of these estimates is the amount to be entered as "current accounts receivable" and used in computing credits.

This procedure permits the physician to charge off bad debts. It also allows him to depreciate the actual value of accounts returned in the tax year, but which have decreased in actual value during that year.

It should be understood that there is no discrimination in the foregoing provisions against

physicians. Every person who possesses intangible assets, such as accounts receivable, or any business or professional man who does business on a credit basis, must return his accounts receivable for taxation.

OHIO SALES AND USE TAX

Section 5739.02 Revised Code levies an excise on each retail sale made in Ohio of tangible personal property.

In Section 5739.01, under the definition of "vendor," the Revised Code states: "Physicians, dentists, hospitals and veterinarians who are engaged in selling tangible personal property as received from others, such as eye glasses, mouth washes, dentifrices, or similar articles, are vendors."

Under the definition of "consumer," the Code states: "Physicians, dentists, hospitals, and blood banks operated by non-profit institutions and persons licensed to practice veterinary medicine, surgery and dentistry are consumers of all tangible personal property purchased by them in connection with the practice of medicine, dentistry, the rendition of hospital or blood bank service or the practice of veterinary medicine, surgery and dentistry."

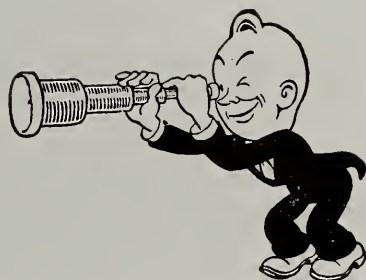
The Ohio Use Tax Law, passed in 1936, supplements the Retail Sales Tax Law and imposes a tax on the same basis as the sales tax on purchases made outside the State. Its purpose is to protect Ohio merchants from discrimination. Many out-of-state firms have made arrangements with the Ohio Department of Taxation to add the amount of the tax to invoices covering purchases by Ohio consumers, collecting the tax and paying it directly to the Department.

However, if a physician purchases drugs or supplies from an out-of-state firm which has not made such an arrangement with the Tax Department, he is required to report such purchases to the Treasurer of State and pay the tax. Returns must be filed with the Treasurer by next April 15 for purchases, during the period January 1 to March 31, and quarterly thereafter. The report is filed on Ohio Use Tax Form 1014, "The Quarterly Consumers Return."

CITY PAYROLL TAX

About 30 cities in Ohio have enacted laws imposing income tax on wage earners and making the employer responsible for deducting the tax from wages paid employees. For example, Columbus has a law which requires the employer to deduct a percentage of the employee's wages and make returns to the city auditor quarterly. A physician who moves into a new location should inquire as to what tax laws may be in force locally.

Looking Ahead



Hotel Reservations

Are Now in Order

For the 1960 ANNUAL MEETING of the OHIO STATE MEDICAL ASSOCIATION. Assure yourself and party excellent accommodations by filling out the coupon below NOW and mailing it to the hotel of your choice. The place is CLEVELAND; the dates, MAY 17, 18 and 19, 1960.

NAME AND LOCATION	SINGLE	DOUBLE	DOUBLE TWIN BEDS
SHERATON-CLEVELAND HOTEL, Public Square (Headquarters Hotel)	\$6.50-11.00	\$10.00-18.00	\$12.00-25.00
AUDITORIUM HOTEL, 1315 East 6th St.	6.00- 9.50	7.50-11.50	11.00-14.00
HOLLENDEN HOTEL, 610 Superior Ave.	6.00-11.00	8.00-12.00	10.00-19.00
MANGER HOTEL, 1802 E. 13th St.	6.00-10.00	9.00-10.50	10.00-14.50
OLMSTED HOTEL, Superior & E. 9th St.	5.00- 8.50	8.50-10.00	8.50-16.00
PICK-CARTER HOTEL, Prospect & E. 9th St.	6.50-10.75	8.50-14.00	11.00-16.00
STATLER HILTON HOTEL, Euclid & E. 12th St.	6.50-14.50	13.00-16.00	14.00-30.00

Persons who desire additional accommodations are advised to specify their needs to the hotels of choice.
(All Rates Subject to Change)

HOTEL RESERVATION BLANK

Mail the coupon to hotel selected

Manager, Cleveland, Ohio
(Name of Hotel)

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, May 17, 18, 19, or for such other period as may be indicated herein.

☐ Single Room with Bath ☐ Double Room with bath Price.....

☐ Twin Bed Room with Bath ☐ Suite

Arriving May.....at.....A. M.....P. M.

PLEASE VERIFY MY RESERVATION

Name

Address

Medical Costs . . .

People Should Be Told in A Positive Way Why They Are High and What They Are Getting for Medical Care Dollar, PR Experts Testify

WHY medical costs are high as well as what people get today for their medical care dollar are stories that should be told in a positive way to the American public.

This was the consensus reached by a group of individuals representing medicine, the hospital and pharmaceutical fields, labor and the insurance industry at the recent American Medical Association Public Relations Institute in Chicago.

An entire morning was devoted to a session titled "Is the Cost of the Trip Too High?" Staged in the style of a congressional committee hearing, the session, which was moderated by George Cooley, secretary of AMA's Council on Medical Service, heard testimony from the following "experts":

Ray Brown, director of the University of Chicago Clinics, pointed out that hospital costs rose from an average \$9.39 per patient a day in 1946 to \$28.17 in 1958, chiefly due to increased labor costs; that since hospitals operate a service business, automation does not effect any saving and wage increases cannot easily be absorbed; that there is little chance hospital costs can be reduced much. Consequently, Brown said, the medical and hospital professions must talk positively about the forces responsible and explain to the public the advances purchased by the legitimate increased cost.

Demand for More Service

Leonard Martin, assistant director of AMA's Economic Research Department, testified that even though today the patient gets more for his money in terms of diagnosis and treatment, medical cost will always be a factor because people invariably want more service. Stressing that deterioration in hospital care would bring on socialized medicine, Martin said if everyone could be insured for hospital care, people wouldn't be concerned about medical care cost.

Fred Roll, director of public relations for Smith, Kline & French, Philadelphia, said that while more money is being spent on medical care, top results are being obtained. New drugs are responsible for great advances; the public does not think drugs are expensive "if they work," Roll said. Today's average prescription price is

\$3.00 but the entire health team must make personal explanations of this fact and the fact that drugs are high risk products to the public.

Lawrence Wells, director of promotional activities for Blue Shield Medical Care Plans in Chicago, said survival of voluntary health insurance depends upon performance of Blue Shield—and extension beyond groups, inclusion of senior citizens, broader coverage and comprehensive public education in regard to indiscriminate demands. Economic understanding is vitally needed in regard to what insurance can and cannot do, Wells said, and he urged the medical profession to take the initiative in conducting such an educational campaign to assure continued free enterprise in medicine.

Arthur Browning, vice-president in charge of group insurance for the New York Life Insurance Company, testified that the health insurance industry is ready and willing to cooperate with the medical and hospital fields to let the public know what the true cost of medical care is. He said the public continually demands broader insurance programs and pointed out that rates must change with changes in service.

What They Are Getting

A recent survey showed that people were more concerned with what they were getting than what they were paying. Browning said abuses of insurance are great in the proprietary hospital field. Since doctors control 95 per cent of these hospitals, the medical profession must determine what is going on, especially in big population areas, and correct these abuses.

James Brindle, Director of the Social Security Department for the United Auto Workers in Detroit, stated the unions want a price tag on medical care and would like to see organized medicine take force in providing service insurance programs. Other indefinite types are unsatisfactory and vague. He also said medical policies should be more medically oriented and added that doctors must run medical care insurance programs. Although unions do not like the deductible features in insurance policies, Brindle said Americans have not yet hit the limit in the amount of wages which people will allocate for medical care if the policy offered is good.

A Surgeon Looks at 35 mm. Color . . .

Capturing the Operating Room Procedure on Film Requires Split-Second Timing and Good Planning; Here Are Hints Based on Actual Experience

By E. MILES FUSCO, M. D., Columbus*

THERE are few places where 35 mm. color gets a sterner test than in the operating room. Here we have swift pulsing motion—warm vital colors—and kaleidoscopic color exchanges ranging from autumnal yellows, reds, and browns to winter-like greys and blues.

Attempts to capture this magnificent panorama have been less than sensational. Part of the trouble has been the time element. Few surgeons are willing to slow the pace of their attack and few technicians are able to analyze their problem in the split seconds allotted them. Lens coating or lack of lens coating presented another major obstacle when lights were bright and reflections rampant. Those bright and slanting rays danced and dodged and flared their way into every crevice of the incision. The failure to match the heavy tungsten lighting of the operating room with the oft uncertain color emulsions provided another stumbling block.

The biggest hurdle was the lens itself. The lenses of years ago did not provide the resolution and flatness of field or capture the infinite detail so precious to the meticulous operator. And you couldn't sneak up on your anatomy then like you do now with your calibrated rare earth glasses.

Nowadays the modern operating room is staked out like the Black Hills during the gold rush.

One manufacturer was clever enough to fit a 35 mm. camera into the heart of the overhead light so that the camera lens never failed to capture the brightest and most important part of the operation. This was fine if you enjoy long distance shots of the sunset in a neighboring county.

Some Simple Rules

After years of trial and error, we finally hit onto a few simple rules that are lifting us from the morass of mediocrity. Here they are:

1. We use a single lens reflex with a pentaprism finder. Since most of our work is macro photography accurate centering and through the lens detail is all important. And hair-breadth focusing at wide apertures is easy.

2. Most still work can be done with four

lenses—the 35 mm. wide angle, the 50 mm. regular, and the 90 and 135 mm. telephoto lenses. We have found the modest distortion of the wide angle lens accentuates the positive. Increase in depth of field is another desirable characteristic of the wide angle.

3. Electronic flash and daylight color film are standard in our operating room. The tungsten lights normally employed in surgery do not seem to interfere with the clean, crisp, and cool electronic flash. The flash units are paired as a rule. Bounce flash has not been satisfactory in our hands. The ring light is useful in particular cases. It is well to remember that explosions can occur with electronic flash.

4. The extra lighting is provided by spot lights of measured Kelvin potential. Since most spot and flood lights are rated at 3200 to 3500 degrees Kelvin, a change to Type A Color film is necessary.

5. A tripod is essential, though the duration of the electronic flash is usually about 1/1000 of a second. For deep cavity work, the camera is dollied into place or a capped and gowned assistant grabs the camera and shoots close up.

6. Good draping is important. Most of the gremlins of color surgery can be eliminated by using neutral or green drapes and permitting few instruments to show in the field. When using dark drapes the exposure reading should be increased one full stop. In most cases it is wise to bracket exposures since you won't get a second chance.

Gift Makes Possible Children's Research Center in Columbus

The M & R Dietetic Laboratories, Inc., Columbus, has announced a gift of \$180,000 toward the proposed research center at Children's Hospital in Columbus. Another gift of \$10,000 from the Ohio Oil Company, Findlay, with Federal matching funds brought the available funds in mid-November to \$370,000, the public press announced.

Plans call for a three-story structure to be built west of the hospital building facing a proposed mall. Total estimated cost is \$450,000.

*Dr. Fusco is assistant clinical professor of surgery, The Ohio State University College of Medicine.

Out of the Blue . . .

More Questions and Answers On the Policies and Operations of Ohio Medical Indemnity, by Physicians' Relations Director of the Company

By R. DEAN DOOLEY, M.D.

Director, Physicians' Relations Department, Ohio Medical Indemnity,
3770 N. High St., Columbus 14, Ohio

HERE is another in the series of articles *The Journal* is carrying on Ohio Medical Indemnity, prepared by Dr. R. Dean Dooley, director of the Physicians' Relations Department of the company, for the information and enlightenment of members of the Ohio State Medical Association.

This article consists of some of the more common questions asked by physicians and subscribers about OMI, its contracts, administrative procedures, etc., and the answers to them.

Q. Do you allow payment for chest X-Rays under the new Major Contract?

A. It is not planned to pay for chest X-Rays. We indemnify for X-Ray procedures for only those conditions in which the patient will be inconvenienced and unlikely to request the procedure. We have no way of knowing what the utilization would be for chest X-Rays. It is possible that after we have gained experience, we may include chest X-Rays at a future date.

Q. What is the difference between an indemnity and a service plan?

A. In an indemnity contract the subscriber is paid a specific amount for a procedure. In a service contract there is a contractual agreement which obligates the physician to accept the indemnity specified for services as payment in full for those subscribers who qualify.

Q. Why are subscribers not more fully informed of the limitations of their contract?

A. It would certainly be desirable to have all of our subscribers well informed of the terms and the limitations of their contract. Unfortunately, we are dealing with human beings and perfection is unobtainable. As you know, it is the great American custom to be ignorant of the contents of their insurance contracts. In the large industrial plants in which large groups are enrolled, it is unlikely that the enrolling agent will be able to spend much time with individuals to indoctrinate them in the contents of their contract. Personnel departments can be helpful and I

presume do answer questions when inquiries are made. Certainly, there is a need for a broad educational program among our subscribers, but I question its effectiveness until the attitude of the public has been changed to be more in tune with their insurance responsibilities.

Q. Why can the new Major Contract not be offered for a lesser fee?

A. Premium rates are calculated quite accurately by men skilled in this field. First, the indemnity schedule is drawn up—the one which is decided by the physicians to be the most desirable in meeting the needs of their patients. The actuary, then translates these figures into premium rates. We are in a very highly competitive field and certainly one of our most effective competitive weapons is favorable premiums and benefits, and you can be sure that this premium rate is set as low as possible. O. M. I. cannot stay in business if it disburses more than it receives. Our premium rates are realistic and compare very favorably with other companies providing similar benefits.

Q. Should the number of sutures be listed on a claim reporting repair of lacerations?

A. The number of sutures may be listed. However, it is more important that the location and extent of laceration be included in the report.

Q. Do Ohio Medical contracts provide coverage for industrial cases?

A. Our contracts do not provide payment of benefits for services for which the cost is payable under State or Federal Workmen's Compensation laws. This question, relative to workmen's compensation cases, is one of the items listed on our claim form.

Q. Can Multiple services performed on different dates be reported on one claim when the same patient is involved?

A. Multiple dates of services on the same patient can be reported on one claim form. Complete details of the services performed on each

date, however, should be included in all the items provided on the claim.

Q. What additional information should be listed when completing a claim blank for a subscriber enrolled through another Blue Cross area?

A. Ohio Medical claim forms are comprised of seven different colors—each color designating a Blue Cross plan. This is one of the means we use in determining a Blue Cross area through which a subscriber is enrolled when he files a claim. When completing a claim for a subscriber enrolled through another Blue Cross area, the name of his Blue Cross plan should be listed in the upper margin.

Q. Are services rendered outside of the state covered by Ohio Medical Indemnity contracts?

A. Services included in Ohio Medical Indemnity contracts are covered when rendered outside of the state or anywhere in the world as long as they are performed by a licensed physician. Ohio Medical has received claims from almost every country in the world.

Q. What is the extent of Ohio Medical coverage for treatment of psychiatric patients?

A. Mental patients receive benefits under in-hospital medical cases when confined in General Hospitals as defined in the contract. Shock treatments are not covered under Ohio Medical contracts.

Q. Is Ohio Medical's radio-therapy coverage for just malignant type of neoplasms?

A. The radio-therapy provisions of our contracts provide indemnity payments for treatment of neoplasms and neoplastic diseases. This applies to both non-malignant and malignant neoplasms.

Q. How does Ohio Medical handle claims for the removal of lesions by excision and electro fulguration?

A. Ohio Medical contracts provide payment of indemnity for the excision or electro fulguration of lesions. Claims reporting the removal of multiple lesions are given additional consideration.

Q. Could there be information listed on patient's identification card which would enable doctors to identify the type of contract held by the subscriber?

A. Yes, it could be added; however, it would be impossible to keep the information current. Statistics show that there is a change in over 38 per cent of the insurance contracts annually.

Governor Reappoints Dr. Dwork State Director of Health

Dr. Ralph E. Dwork has been reappointed director of the Ohio Department of Health for a five-year term by Governor Michael DiSalle. The appointment, became effective November 8, immediately after expiration of the previous term.

Dr. Dwork first became associated with the Ohio Department of Health in 1950 as chief of the Division of Tuberculosis and a year later was made chief of the Division of Chronic Diseases. He became assistant director in 1954 and later acting director, receiving the top post on November 8, 1954.



R. E. Dwork, M. D.

The new five-year term began on November 8 of this year. Under the re-appointment, Dr. Dwork benefits from this year's

action of the Ohio General Assembly increasing the salary bracket from \$12,000 to \$18,000.

Dr. Dwork did extensive work in the field of tuberculosis before coming to Ohio and prior appointments include that as health officer for the New York City Health Department. He also has a master's degree in public health from Columbia University. Dr. Dwork is a member of the Columbus Academy of Medicine, the Ohio State Medical Association and the American Medical Association.

Cleveland EEG Society Elects Officers

The Cleveland Electroencephalographic Society, founded in 1948 to promote the art and science of electroencephalography, held a meeting October 26 at the Cleveland Clinic. Dr. Andre Weil presented a talk on "Ictal Emotions in Temporal Lobe Dysfunction."

Mr. Julius Siroky reported that the Ohio Society of Electroencephalographic Technicians had been formed and met August 29. This regional group planned to affiliate with the National Association of Electroencephalographic Technicians, recently formed as an auxiliary of the American EEG Society.

An election of officers was held. Victor M. Victoroff, M. D., was elected president; Nelson G. Richards, M. D., was elected secretary-treasurer.

In Memoriam . . .

Harry C. Barr, M. D., Cleveland; Cleveland Pulte Medical College, 1904; aged 77; died October 24; member of the Ohio State Medical Association and the American Medical Association. A native of Cleveland, Dr. Barr practiced there for some 44 years before he retired in 1947. A member of several Masonic bodies and the Methodist Church, he is survived by a daughter and a son, Dr. Harry R. Barr, also of Cleveland.

Ezra Burnett, M. D., Delphos; Ohio Medical University, Columbus, 1893; aged 91; died October 9; member of the Ohio State Medical Association and the American Medical Association. A native of Van Wert County, Dr. Burnett moved to Delphos in 1900 after practicing for about seven years in Wetzell. He continued in practice there until his recent illness. A past-president of the Academy of Medicine of Lima and Allen County, he was active in a number of local affairs, including the board of health and the board of education. He was a member of the Knights of Pythias, several Masonic bodies and the Methodist Church. Survivors include his widow and a daughter.

Everett N. Collins, M. D., Cleveland Heights; Rush Medical College, 1924; aged 63; died November 6; member of the Ohio State Medical Association, the American Medical Association, American Gastro-Enterological Association; Fellow of the American College of Physicians; diplomate of the American Board of Radiology and the American Board of Internal Medicine. Dr. Collins was for 23 years head of the Department of Gastroenterology at the Cleveland Clinic and held the appointment as professor of gastroenterology at the Bunts Education Institute. Surviving are his widow, a daughter, two sons and his father. One son, Dr. Jack Collins, is in residency training at Duke University.

Erwin C. Froelich, M. D., Cleveland Heights; Frederich Wilhelms University Faculty of Medicine, Berlin, 1899; aged 83; died October 31; member of the Ohio State Medical Association and the American Medical Association. A native of Germany, Dr. Froelich came to this country in 1938. He practiced in Cleveland until his retirement about three years ago. Surviving are his widow, a daughter and a son.

George W. Heffner, M. D., Columbus; Starling Medical College, Columbus, 1895; aged 88; died October 7; former member of the Ohio State Medical Association. Dr. Heffner practiced medi-

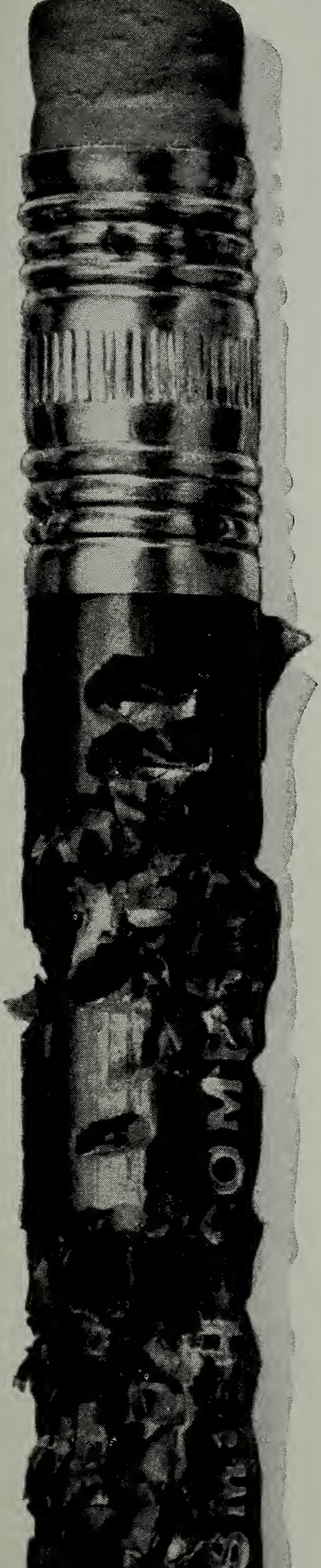
cine for 53 years in Circleville where he was active in a number of community programs and was former County health officer. Affiliations included membership in the Elks Lodge. After retiring in 1949, Dr. Heffner made his home in Columbus for a number of years. He died in Wallingford, Pa., where he was visiting his surviving daughter.

Fred W. Heinold, M. D., Cincinnati; University of Cincinnati College of Medicine, 1924; aged 62; died October 20; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. A practicing physician in Cincinnati for many years, Dr. Heinold participated in a number of community activities and was particularly interested in the field of education. He was president of the Cincinnati Board of Education for 19 years; was a past-president of the Ohio State School Board Association and a past-president of the Southwestern Ohio District Board of Education. He was active in high school athletic work, the YMCA and the Red Cross. Affiliations included memberships in several Masonic bodies and the Eagles. Surviving are his widow, two sons, a daughter, two sisters and a brother.

Carl W. Iuler, M. D., Columbus; Ohio State University College of Medicine, 1926; aged 61; died November 3; member of the Ohio State Medical Association and the American Medical Association. A practicing physician for many years in Columbus, Dr. Iuler had done graduate work at Johns Hopkins and at the Ford Hospital. His widow and a brother survive.

D. S. Jevrem, M. D., Canton; University of Paris Faculty of Medicine, France, 1923; aged 63; died November 21; member of the Ohio State Medical Association and the American Medical Association. A native of Yugoslavia, Dr. Jevrem practiced in that country and in France before coming to the United States in 1950. He began practice in Canton in 1955. Surviving are his widow, two sons and a brother in this country, and another brother, two sisters and his mother in Yugoslavia.

Perry A. Jividen, M. D., Rutland; Starling Medical College, Columbus, 1902; aged 83; died October 31; member of the Ohio State Medical Association and the American Medical Association. Dr. Jividen practiced medicine for 54 years in



when you see
signs of
anxiety-tension
specify

Dartal[®] dihydrochloride
brand of thiopropazate dihydrochloride

for rapid relief of anxiety manifestations

You will find Dartal outstandingly beneficial in management of the anxiety-tension states so frequent in hypertensive or menopausal patients. And Dartal is particularly useful in the treatment of anxiety associated with cardiovascular or gastrointestinal disease, or the tension experienced by the obese patient on restricted diet. You can expect consistent results with Dartal in general office practice.

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Clinical reports on Dartal: 1. Edisen, C. B., and Samuels, A. S.: A.M.A. Arch. Neurol. & Psychiat. 80:481 (Oct.) 1958.
2. Ferrand, P. T.: Minnesota Med. 41:853 (Dec.) 1958.
3. Mathews, F. P.: Am. J. Psychiat. 114:1034 (May) 1958.

SEARLE

Rutland before his retirement several years ago, and in 1952 was honored with the 50-Year Award of the Ohio State Medical Association. He is survived by his widow and a daughter.

Jeremiah E. Kerschner, M.D., Tiffin; Ohio State University College of Medicine, 1914; aged 69; died October 27; member of the Ohio State Medical Association and the American Academy of General Practice. Dr. Kerschner practiced for 40 years in Columbus. He moved to Tiffin about a year ago where he was associated with the Tiffin State Hospital. Survivors include his widow, a son, and two daughters.

Neil T. McDermott, M.D., Cleveland; Harvard Medical School, 1932; aged 54; died August 24; member of the Ohio State Medical Association, the American Medical Association and the American Psychiatric Association; diplomate of the American Board of Psychiatry and Neurology. Dr. McDermott moved to Cleveland in 1937 where he was on the staff of University Hospitals and on the faculty of Western Reserve University College of Medicine. He entered full-time practice in 1946. Survivors include his widow, two sons, a daughter and five sisters.

John Gregory Martin, M.D., Wadsworth; Western Reserve University School of Medicine, 1916; aged 69; died October 12; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. Born in Pakistan of missionary parents, Dr. Martin returned there as medical missionary and remained for 15 years. He returned to the United States in 1934, practiced at Clinton until he moved to Wadsworth in 1942. A member of the Presbyterian Church, he is survived by his widow, three daughters, a son, two sisters and a brother.

Jacob D. Rosenman, M.D., Akron; Columbia University College of Physicians and Surgeons, 1916; aged 74; died October 21. Dr. Rosenman was retired after practicing years ago in Akron and engaging in business operations there. A member of B'nai B'rith, he is survived by his widow, two daughters, a son, two sisters and three brothers.

Abram Jackson Shoemaker, M.D., Columbus; Ohio State University College of Medicine, 1909; aged 75; died October 25; member of the Ohio State Medical Association and the American Academy of General Practice. A physician in the Columbus area for more than a half century, Dr. Shoemaker continued practice on a limited basis to the time of his death. A veteran of

World War I, he was a member of the American Legion. Other affiliations included memberships in several Masonic bodies and the Methodist Church. Surviving are his widow, two daughters, a brother and two sisters.

George B. Tupper, M.D., Cleveland; New York University College of Medicine, 1910; aged 78; died October 13; member of the Ohio State Medical Association and the American Medical Association. A practicing physician in Cleveland since 1912, Dr. Tupper's professional services included that as surgeon for the Pennsylvania Railroad. He was active in the Masonic Lodge and the Methodist Church. Survivors include his widow and a sister.

Ophthalmology To Be Subject At Ohio State Course

A Postgraduate Course in Ophthalmology will be given by the Department of Ophthalmology, Ohio State University, on Monday and Tuesday, March 7 and 8, in the Ohio Union Building on the campus. Registration will open at 8:00 a. m. with the program beginning at 9:00 a. m. Registration fee is \$20. Inquiries may be addressed to: William H. Havener, M.D., Department of Ophthalmology, University Hospital, Columbus 10, Ohio.

Subjects and features have been announced as follows:

Moderator, Dr. James M. Andrew.

Experiences with the Light Coagulator, Dr. Havener.

Alpha Chymotrypsin, Dr. Rocko Fasanella, New Haven, Conn.

Anisometropic Prescriptions, Paul Boeder, Ph. D., Iowa City.

Ocular Changes in Dermatologic Disease, Dr. Phillips Thygeson, San Jose, Calif.

Ocular Fungus Infections, Dr. Torrence A. Makley, Columbus.

Magnification and Telescopic Lenses, Dr. Boeder.

Dinner meeting with Columbus Academy of EENT.

Nasolacrimal Surgery, Dr. Fasanella.

Keratitis, Dr. Thygeson.

Modern Therapy of Sympathetic Ophthalmia, Dr. Makley.

Complications of Cataract Surgery, Dr. Fasanella.

Conjunctivitis, Dr. Thygeson.

Accommodation - Convergence Relationships, Dr. Boeder.

Services for You, Dr. Havener.

Some Interesting Facts on How Long Patients Stay in Hospitals

Seven out of every ten persons admitted to hospitals stay seven days or less, the Health Insurance Institute reported.

Some 88 per cent of all admissions stay 14 days or less and 96 per cent stay 30 days or less, the Institute added in its report on a U. S. National Health Survey of hospitalization in the nation over a 12-month period.

Several studies have indicated that the average length of hospital stay per patient has declined considerably in the post-war years. Programs of all health insurance organizations, said the Institute, have been expanded to meet the needs of modern hospital services.

A recent survey of 188 insurance companies disclosed that all provided policies with benefits for more than 30 days of hospitalization, and that 174 companies had policies with benefits for 90 days or more, said the Institute.

More than 123 million Americans had hospital expense insurance at the end of 1958. Insurance companies, Blue Cross, and independent health care plans paid benefits of \$2.6 billion in 1958 for hospital care alone, out of a total of \$4.7 billion in health insurance benefits, said the Institute.

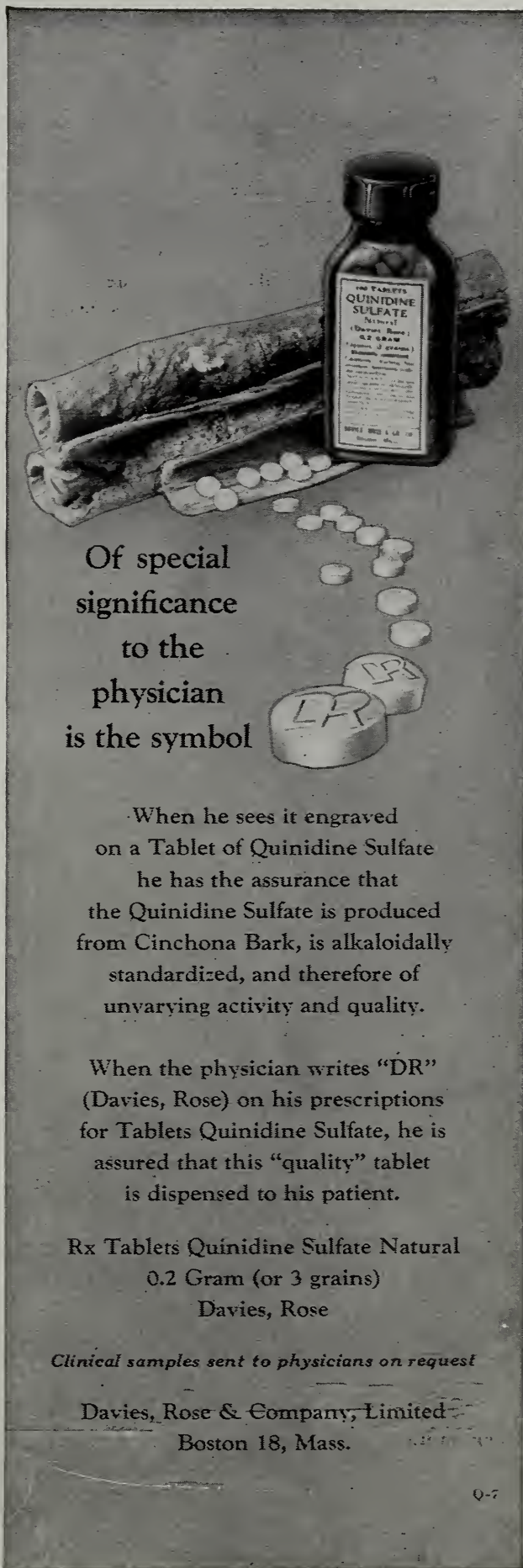
The National Health Survey revealed that women were hospitalized more frequently than men but stayed for a shorter period of time. Women were hospitalized at a rate of 123 per 1,000 to 74 per 1,000 among men, but stayed seven days on the average to 11 days among men.

The higher rate of admission among women was attributed generally to maternity which probably also played a significant part in the surprising finding that the highest hospitalization rate by age group came in the 15-24 bracket where 137 out of every 1,000 experienced a hospitalization episode. The lowest rate was among children under 15 where 53 out of every 1,000 were hospitalized.

By region of the U. S., the highest hospitalization rate was in Midwest where 105 of every 1,000 persons entered the hospital during the year. The West had a rate of 100, the Northeast followed with 97, and the South had lowest, 95.

Of all admissions to the hospital during the year of the study, six out of 10 were surgically treated and four of 10 were not surgically treated. Surgical cases stayed, on the average, 7.5 days while non-surgical cases stayed 10.3 days.

The study showed that 99 out of every 1,000 persons in the U. S. were hospitalized during the year, and that they stayed in the hospital an average of 8.6 days.



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Q-7

Resolutions for 1960 Annual Meeting Must Be Sent To Columbus Office On or Before March 17

HERE is an important item for County Society officers and delegates: Resolutions to be acted upon at the 1960 Annual Meeting, Cleveland, in May, must be in the hands of the Executive Secretary on or before March 17 or they cannot be introduced without the consent of two-thirds of the House of Delegates.

This provision is found in Section 8, Chapter 4 of the Bylaws of the State Association. Also, the Bylaws provide that resolutions shall be presented at the opening session of the House of Delegates — on Monday evening, May 16, in 1960.

After receiving resolutions which delegates are planning to introduce at the first session of the House of Delegates on Monday evening, May 16, the Executive Secretary will present them to *The Journal* for publication and, later, will send copies to all certified delegates.

Experience With Bat Bites Throws Light on Rabies Precautions

Following is a statement from Dr. Winslow J. Bashe, Jr., chief of the Division of Communicable Diseases, Ohio Department of Health:

Decisions concerning the advisability of giving anti-rabies therapy following animal bites are difficult ones. The demonstration of Negri bodies in the brain of the animal is frequently used by the physician in deciding whether to continue or initiate vaccine therapy and to discontinue it in those cases where Negri bodies cannot be found.

The dangers in following such a procedure are exemplified by two recent cases:

(1) Two boys in southwestern Ohio were bitten by a big brown bat. The brain of this bat was negative for Negri bodies so anti-rabies therapy was not initiated. Three weeks later Negri bodies were demonstrated in mice inoculated from the same brain suspension.

(2) A woman in eastern Ohio was bitten or scratched by a little brown bat. The brain of this animal showed no evidence of Negri bodies but mice inoculated with this material died 12 days later and Negri bodies were demonstrated in their brains. No treatment was started for 14 days after exposure.

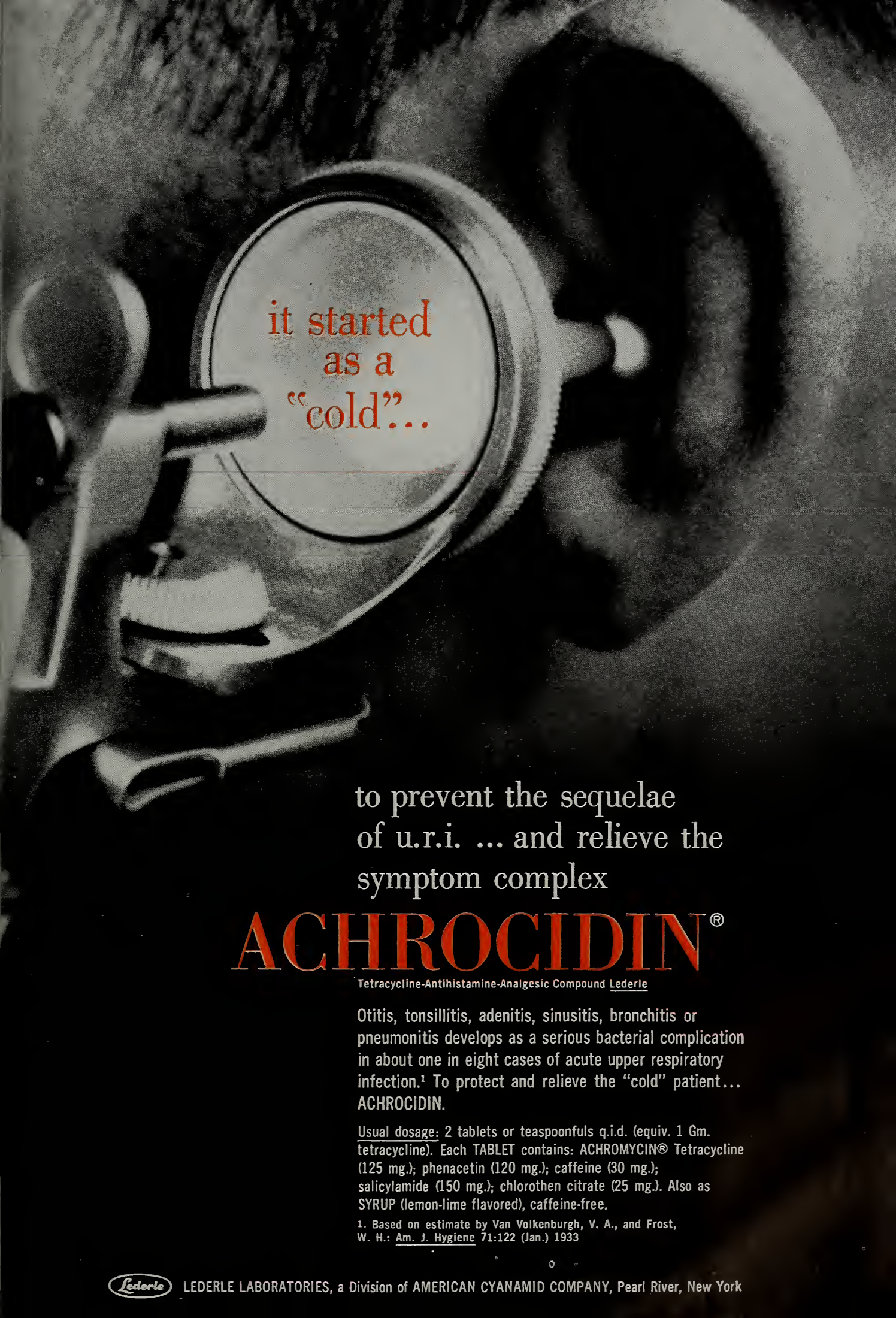
Although these persons did not succumb from rabies, this was not due to therapy which in either instance was started weeks late. These cases demonstrate the lack of reliability in the Negri body test especially in bats and the importance of beginning anti-rabies therapy immediately in the case of bat bites in spite of negative results in this test.

A recommended procedure for treatment of animal bites has been prepared by the Ohio Department of Health and is available on request.

Policy on Hospital Emergency Admissions In Cincinnati

The following joint policy on emergency admissions to hospitals has been approved by the Cincinnati Academy of Medicine and the Greater Cincinnati Hospital Council:

(1) It is the agreed policy of the Academy of Medicine of Cincinnati and the Greater Cincinnati Hospital Council that a patient may select his own physician in an emergency case regardless of such physician's affiliation with the hospital of the patient's choice. Courtesy privileges for the duration of emergency cases only shall be extended to all reputable physicians who are duly licensed. The Administrator and the Chief of the respective department of such hospital shall determine whether or not the physician is reputable and medically competent to render the type of emergency care required in the particular case at hand. (2) Appointment to the Attending Staff of a hospital carries with it obligations as well as recognition on the part of the physician so appointed. Hospitals have an obligation to assist the physician in providing the best health care for his patients. (3) Broad Courtesy Staff privileges in the Community's hospitals provide flexibility in facilities and assure maintenance of the doctor-patient relationship. The Joint Committee suggests that Courtesy Staff privileges be broadened as much as possible, consistent with competent medical practice and hospital administration. (4) Since ultimate responsibility for hospital operations rests with the Boards of Trustees or controlling authorities of the various hospitals, it is the desire of this Joint Committee to reaffirm that determination of "competent medical practice and hospital administration" rests with the Board or controlling authority in consultation with each hospital's medical staff.



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1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933



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Tissue Committee . . .

Standards Recognized by Commission on Accreditation Enumerated In Official Statement; Value of Committee and Its Activities Discussed

VALUE of a properly functioning tissue committee in a hospital and how such a committee should function were discussed in a special statement issued recently by the Joint Commission on Accreditation of Hospitals in which an effort is made to clarify the standards recognized by the Commission on this subject. Following is the major portion of the Commission's statement:

Text of Statement

"Few persons question that the tissue committee, functioning properly, is one component of medical staff organization which has strengthened and improved the quality of medical care in hospitals. To be effective, committee reports are necessary and to insure their proper use, the hospital medical staff should make certain that this committee functions as an educational tool and not as a disciplinary device.

"All physicians abhor incompetent or unethical work. Section No. 4 of the Principles of Medical Ethics as adopted by the American Medical Association reads as follows: "The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession, and accept its self-imposed disciplines. They should expose without hesitation, illegal or unethical conduct of fellow members of the profession."

Judge and Be Judged

"Physicians are understandably reluctant to sit in judgment of their colleagues. Then there are those who believe that only the individual himself can judge his own capabilities. However, when doctors choose to associate themselves in a community effort, like that of a hospital medical staff, it necessarily follows that there must be rules and regulations and the individual becomes responsible not only for his own performance, but for that of others. He shows willingness to both judge and be judged.

"The tissue committee's main function is that of improving surgical care of patients by the review of documented work. Thus this committee's work is one of continuing education. The influence of the tissue committee should be

that of a positive nature. It should be more than a negative or inhibiting influence. It should not be content solely to abolish outmoded or discredited techniques and procedures. It should strive for the adoption of better methods of treating patients and of curing disease. It attains these objectives by continuing analysis, review and education.

Modus Operandi

"As a suggestion for the modus operandi of a tissue committee, a hypothetical situation is set up. Hospital X is a 135 bed general hospital. Its tissue committee is made up of two surgeons, a gynecologist, an internist and a general practitioner. The pathologist is an ex-officio member of the committee without vote, acting in an advisory and consultative capacity. (In hospitals without a pathologist his reports are utilized if he cannot be present). The hospital medical record librarian tabulates all operations on a work sheet which includes the following items:

1. Tissue Number
2. Age
3. Hospital Number
4. Pre-operative Diagnosis
5. Post-operative Diagnosis
6. Operative Procedure
7. Tissue Removed
8. Pathological Diagnosis
9. Normal Tissue
10. Acceptable—Yes or No.

"The medical record librarian records items No. 1 through No. 7. The pathologist completes items No. 8 and No. 9. The tissue committee after studying the work sheet, reviews the charts, and on the basis of the record completes item No. 10 as to the agreement or disagreement among the preoperative, post-operative and pathological diagnoses, whether the record shows that the surgical procedure performed was clearly indicated, and whether the quality of work was acceptable to the committee.

Report of Committee

"The tissue committee then synthesizes the work sheets and writes out the committee report to the executive committee of the medical staff somewhat

as follows: 'The tissue committee reviewed the 100 operations performed in this hospital during the last month. Ninety of the operations raised no questions. Eight of the remaining operations were reviewed by the committee with the attending physicians and with additional information, need no further comment. These physicians were requested to document records more fully in the future. The last two cases are referred to the executive committee for disposition.' After the executive committee has received and acted upon the report, the work sheets have served their purpose and the Commission does not require that they be kept. It is assumed that members will respect the confidential nature of the work of the committee.

"The tissue committee's work should not stop here. It has a further educational responsibility. The findings of the committee in the form of hypothetical cases or a review of cases by categories should be utilized at staff meetings for the advancement of high quality care. Working with the staff program committee, symposiums can be arranged on new techniques and therapeutics that have proven superior. All interests are directed toward better patient care through review and continuing education."

New Members of OSMA

The following are the names of the new members of the Ohio State Medical Association since October 1, 1959. The list shows the county in which they are affiliated, city in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

Ashland County

Chalfant, Henry C., Ashland
Reich, Lorand C. A.,
Loudonville

Cuyahoga County

Coviello, James J.,
Cleveland
Desberg, Daniel, Cleveland
Kelly, Harold B., Cleveland
Kiwala, Raymond A.,
Cleveland
Lozano, Enrique A.,
Strongsville
Post, Robert S., Cleveland
Zsako, Steven, Cleveland

Lorain County

Williams, Thomas E.,
Grafton

Lucas County

Armstrong, Carl L., Toledo
Black, Charles E., Toledo
Draheim, Jerry W., Toledo

Mahoning County

Marcella, Hendrik J. W.,
Youngstown
Whitten, Charles A.,
Youngstown

Pickaway County

Alvarez, Carlos, Circleville

Sandusky County

Lane, John F., Fremont

Wood County

Baldoni, Louis P.,
Perrysburg

The Air Force School of Aviation is moving to new quarters at Brooks Air Force Base, San Antonio, Texas, having been located at Randolph Air Force Base near San Antonio since 1931.



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The State Medical Board of Ohio has issued licenses to practice medicine and surgery in the State to the following physicians through endorsement of their licenses to practice in other states, or certification by the National Board of Medical Examiners (included are intended residence and medical school of graduation):

August 26—Nico Capurro, Univ. of Naples; George Lee Fifer, Springfield, Medical College of Virginia; Jerome L. Gauthier, Columbus, Univ. of Ottawa; C. Northcott, Hinman, Jr., Cleveland, Univ. of Michigan; Richard H. Spitz, Columbus, Washington Univ.; Virginia N. Weatherhead, Willoughby, Tulane Univ.; Vincent E. Zuitmeyer, Chesterland, Univ. of Illinois.

October 6—Patricia A. P. Carlough, New Concord, Univ. of Michigan; Robert R. Clark, Cuyahoga Falls, Univ. of Michigan; Samuel N. Dulin, Jr., Toledo, George Washington Univ.; Bertram Eckert, Univ. of Zurich, Switzerland; Heinz J. Ext, Univ. of Berlin, Germany;

Richard A. Freiberg, Cincinnati, Harvard Medical School; Afonso B. e Gala, Toledo, Univ. of Coimbra, Portugal; George I. Harrison, Univ. of Lausanne, Switzerland; Leonard M. Heinz, Toledo, Univ. of Wisconsin; Robert E. Hermann, Cleveland, Washington Univ.;

Harris H. Kanel, Cleveland, Univ. of Buffalo; John S. Jacoby, Dayton, Wayne University; Julius M. Klaus, Cincinnati, Indiana University; Paul H. Klingenberg, St. Louis Univ.; Eric W. Lauter, Steubenville, University of Chicago;

Robert H. Lowe, Lima, Univ. of Vermont; John D. Lucker, Cleveland, Univ. of Rochester; Alfred L. Mauro, Univ. of Rome, Italy; Nejdatt Mulla, Youngstown, Univ. of Geneva, Switzerland; Donald L. Oberlin, Akron, Univ. of Texas (Southwestern); Albert O'Halloran, Tiffin, National University of Ireland (Galway); Tuathal P. O'Maille, Columbus, National University of Ireland (Galway); Bohdan S. Osadca, Dayton, Univ. of Erlangen, Germany;

Raymond E. Phillips, Dayton, Yale University; Josefina C. Rodriguez, Santo Domingo Univ., Dominican Republic; Walter H. Schwartz, Delaware, Univ. of Iowa; Lester D. Shultis, Canton, Cornell Univ.; Pedro B. Vallejo, Cleveland, Univ. of Santo Tomas, Philippines;

Richard D. Wells, Lakewood, State Univ. of Iowa; Wilk O. West, Columbus, Medical College of Virginia; Larkin M. Wilson, Jr., Cleveland, Univ. of Oklahoma.

Cook County Graduate School of Medicine

INTENSIVE POSTGRADUATE COURSES

STARTING DATES — WINTER, 1959 - 1960

SURGERY—Surgical Technic, two weeks, Nov. 30, Feb. 1. Surgery of Colon & Rectum, one week, Nov. 30, Jan. 25. General Surgery, two weeks, Dec 7. Blood Vessel Surgery, one week, Nov. 30.

GYNECOLOGY & OBSTETRICS—Vaginal Approach to Pelvic Surgery, one week, Feb. 1. Office & Operative Gynecology, two weeks, Feb. 9. General & Surgical Obstetrics, two weeks, Feb. 22.

UROLOGY—Two-week intensive course, Apr. 22. Ten-day practical course in Cystoscopy, by appointment.

RADIOLOGY—Diagnostic Radiology, two weeks, Nov. 30.

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Activities of County Societies . . .

First District

(COUNCILOR: CHARLES W. HOYT, M. D.,
CINCINNATI)

HAMILTON

The Academy of Medicine of Cincinnati held a joint meeting with the Cincinnati Surgical Society on November 17 at the Hotel Alms in Cincinnati. Speaker was Dr. Henry Swan II, professor and head of the Department of Surgery, University of Colorado School of Medicine, who discussed "The Treatment of Cardiac Arrest."

A number of specialty groups also held meetings during the month.

HIGHLAND

Dr. J. B. Glenn, of Greenfield, retired, and Dr. William M. Hoyt, of Hillsboro, were presented with certificates and pins symbolic of their 50 years of service in the medical profession, at a dinner meeting of the Highland County Medical Society held Wednesday, November 11, at Snow Hill country club.

Dr. Frank Mayfield, of Cincinnati, president of the Ohio State Medical Association, spoke on behalf of the State Association and also extended his personal felicitations.

Dr. Charles Hoyt, of Cincinnati, Counsellor of the First District, OSMA, and the son of Dr. W. M. Hoyt, presented the certificates and the 50-year lapel buttons to his father and Dr. Glenn.

Dr. Glenn retired in 1955.

Dr. Hoyt has resumed part-time practice following his recovery from injuries suffered in a fall last year.

Both Dr. Glenn and Dr. Hoyt spoke briefly of their professional experiences, the progress made in the science of medicine, and the great service rendered to mankind by their profession.

Dr. Glenn entered practice in Greenfield on February 2, 1911.

Dr. Hoyt entered practice with his father in Hillsboro in April, 1912. He served as county health commissioner for 19 years and as coroner for 14 years. He has been a member of the Ohio State Medical Board continuously since 1938.

Dr. J. Martin Byers, president of the Highland County Society, was chairman of the program. Mack Sauer was master of ceremonies.

Dr. Clifford Foor, of Hillsboro, and Dr. John Anderson, of Lynchburg, arranged the affair.

Other guests were Dr. H. M. Platter, of Columbus, who has been executive secretary of the Ohio State Medical Board for 51 years; Charles

S. Nelson, Columbus, Executive-Secretary of the OSMA, and Dr. Edwin Artman, of Chillicothe, President-Elect of OSMA, and Mrs. Artman.

Second District

(COUNCILOR: RAY M. TURNER, M. D., SPRINGFIELD)

DARKE

The subject, "Pediatric Surgery," was discussed at the October 20 meeting of the Darke County Medical Society in Greenville at the Fairlawn restaurant. Speaker was Dr. Adrian Jensen, Dayton.

MIAMI

"Surgical Emergencies in the Newborn" was the subject discussed at the November 6 meeting of the Miami County Medical Society at the Stouder Memorial Hospital, Troy. Speaker was Dr. Alan D. Shafer, of Dayton.

Third District

(COUNCILOR: FLOYD M. ELLIOTT, M. D., ADA)

SENECA

Dr. Victor L. Magers, who has been a practicing physician for 50 years, was honored Tuesday night (October 13) when members of the Seneca County Medical Society gave a dinner at Wyme's restaurant.

At the after dinner program, Dr. Floyd Elliott, of Ada, Councilor of the OSMA Third District, presented Dr. Magers with a plaque and a gold pin from the State Association, and Dr. Thomas W. Watkins presented an engraved gold watch to Dr. Magers on behalf of the Seneca County Medical Society.

Drs. Robert C. Chamberlain and Paul J. Leahy paid tribute to Dr. Magers for his pioneering work in the medical profession in the city. Dr. Magers, it was brought out, was the first doctor in the city to use x-ray.

Fifty attended the dinner, including doctors and their wives. Dr. Watkins was in charge of arrangements.—*Tiffin Advertiser-Tribune*.

Fourth District

(COUNCILOR: W. W. GREEN, M. D., TOLEDO)

DEFIANCE

At the November 7 joint meeting of the Defiance County Medical Society and the staff of city hospital, a local physician, Dr. John Cameron gave interesting facts on the subject of "Mucocutaneous Lesions of Reiter's Syndrome" with a film presentation. At the same meeting also was shown a film on a symposium on "Vascular Head Pain"

(Continued on Page 1706)

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presented by the New England Medical Center. The group nominated new staff officers for the hospital for 1960. — Julian Movchan, M. D., Correspondent.

LUCAS

The Academy of Medicine of Toledo and Lucas County had the following features on the calendar for the month of November:

General Section, November 6—"Africa—Land of Progress," Mary Clark Anderson, Minister of Music, Monroe Street Methodist Church, Toledo.

Section on Pathology, November 13—"Contribution of Biopsy Technics to the Diagnosis of Digestive Diseases," Dr. William S. Haubrich, Division of Gastroenterology, Henry Ford Hospital, Detroit.

Surgical Section, November 20—"Perforated Peptic Ulcer," Dr. Dragoljub Vasiljevich, visiting exchange doctor from Yugoslavia.

Fifth District

(COUNCILOR GEORGE W. PETZNICK, M. D.,
CLEVELAND)

LAKE

The Lake County Medical Society, in conjunction with the Department of Obstetrics and Gynecology of Lake County Memorial Hospital, presented an outstanding Symposium on Obstetrics and Gynecology on October 28 at Hellriegel's Inn, in Painesville.

Six doctors from Johns Hopkins, Ohio State and Western Reserve Universities presented the afternoon and evening sessions, which were attended by more than one hundred physicians from northeastern Ohio and western Pennsylvania. Fifteen interns and residents from hospitals in the area also attended.

Dr. Paul W. Hanahan, chairman of the Department of Obstetrics and Gynecology at Lake County Memorial Hospital, acted as chairman of the Symposium and introduced the speakers:

Dr. Edmund R. Novak, assistant professor of gynecology and female urology at Johns Hopkins University School of Medicine, spoke on "The Relationship Between Endometrial Adenocarcinoma and Endometrial Hyperplasia."

Dr. Nichols Vorys, director of the Gynecologic Endocrinology Section in the Department of Obstetrics and Gynecology at Ohio State University, spoke on "Hemolytic Disease in the Newborn."

Dr. Willard T. Hill, formerly associate professor of pathology at Northwestern University Medical School, and now pathologist at Lake County Memorial Hospital, presented a paper on "Pregnancy Tests."

"Carcinoma in Situ of the Cervix" was the subject of the talk given by Dr. Gerald A. Galvin,

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assistant professor of Gynecology at Johns Hopkins.

Dr. Allan C. Barnes, professor and chairman of the Department of Obstetrics and Gynecology at Western Reserve University, presented an interesting talk titled "Creation of Error."

After a break for a social hour and dinner, all of the speakers participated in an interesting and lively discussion titled "The Psychology of Women." The panel moderator was Dr. Roger B. Scott, associate professor of obstetrics and gynecology of Western Reserve University School of Medicine.

The Symposium was declared an unqualified success by all who attended, and it is planned to make it an annual affair.—Mrs. Owen A. McLaren, Executive Secretary.

Sixth District

(COUNCILOR: ROBERT T. TSCHANTZ, M. D., CANTON)

STARK

"Renal Origin of Essential Hypertension," was the subject discussed by Dr. Harry Goldblatt, director of laboratories, Mt. Sinai Hospital, Cleveland, at the November 12 meeting of the Stark County Medical Society.

On November 28, the Canton Academy of Medicine held a dinner dance at the Onesto Hotel.

SUMMIT

The Summit County Medical Society is now sponsoring its own emergency telephone and answering service with offices in the Second National Building, Akron. A non-profit corporation has been organized to provide the 25-hour service known as the Summit County Medical Service Bureau. Officers are Dr. Arthur Dobkin, president; Dr. Donald Minnig, vice-president; and Mr. S. H. Mountcastle, Medical Society executive secretary, secretary-treasurer.

The Akron Beacon-Journal carried the following report:

Five 50-year physicians have been recognized

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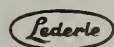
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Dr. Edwin W. Breyfogle, now retired, a general practitioner who was graduated from the old Starling Medical College in Columbus.

Dr. Frank V. Dunderman, a general practitioner who was graduated from the old Cleveland College of Physicians and Surgeons.

Dr. Andrew J. Devany, an internal medicine specialist, who was graduated from Northwestern University.

Dr. Anthony J. Keeley, a general practitioner who was graduated from Queens University, Ontario, Canada.

Dr. Charles E. Updegraff, a general practitioner who was graduated from the University of Pennsylvania.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

SCIOTO

The Scioto County Medical Society met at Mercy Hospital Nurses Home on November 9. Speaker was Dr. William O. Robertson, Department of Pediatrics, Children's Hospital, Columbus, who discussed "Polio Vaccine."

Tenth District

(COUNCILOR: ROBERT M. INGLIS, M. D., COLUMBUS)

MADISON

The regular monthly meeting of the Madison County Medical Society was held on September 9 in the Red Brick Tavern, Lafayette.

Corrected copies of the Society's Constitution and Bylaws and the booklet entitled "Family Fall-out Shelter" were distributed. A letter of resignation submitted by the secretary-treasurer was read and the resignation was accepted with regret and with a vote of commendation for his efforts during the past two years.


President W. T. Bacon outlined the primary objectives of the Society for the year and stated that he considered the formulation of an acceptable set of bylaws to govern the organization and operation of the staff of the proposed Madison County Hospital the first order of business.—Paul G. H. Wolber, M. D., Secretary.

The Eleventh Annual Symposium on Recent Advances in the Study of Venereal Diseases will be held April 7 and 8 in the Palmer House, Chicago. The symposium is sponsored by the American Venereal Disease Association and the U. S. Public Health Service. A seminar for public health personnel precedes this program.

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Proctology Program Offered At Cleveland Clinic

The Frank E. Bunts Educational Institute affiliated with the Cleveland Clinic Foundation is offering a postgraduate course in surgery Wednesday and Thursday, January 13 and 14.

The course will be held in the North Clinic Building located at Euclid Avenue and East 93rd Street.

Inquiries should be addressed to the Institute at 2020 East 93rd Street, Cleveland 6, Ohio. The program includes the following subjects and speakers. Speakers are members of the Cleveland Clinic staff unless otherwise indicated.

Wednesday Morning

Dr. Stanley O. Hoerr, Presiding

Congenital Abnormalities of the Colon and Rectum, Dr. Robert D. Mercer.

Colonic Diverticulitis, Dr. Rupert B. Turnbull, Jr.

Roentgen Diagnosis by Cinefluorography, Dr. C. Robert Hughes.

Vascular Occlusion of the Intestine, Dr. Richard C. Britton.

Urologic Complications of Left Colon Surgery, Dr. Charles C. Higgins.

The Nearby Colon in Gastric Surgery, Dr. Hoerr.

Pathology of Ulcerative Colitis and Regional Enteritis, Dr. George Lumb, James Walker Memorial Hospital, Wilmington, N. C.

Regional Ileitis; Clinical and Immunological Observations, Dr. George Crile, Jr., and Dr. Donald A. Senhauser.

Medical Treatment of Regional Enteritis, Dr. Charles H. Brown.

Surgical Aspects of Ulcerative Colitis, Dr. Turnbull.

Wednesday Afternoon

Dr. George Crile, Jr., Presiding

Tour of Surgical Pavilion and Clinic Proctology Departments.

Pathologic Aspects of Recto-Colonic Cancer, Dr. Lumb.

Conservative Treatment of Certain Polypoid Tumors of the Lower Bowel (Movie), Dr. Raymond Jackman, Mayo Clinic, Rochester Minn.

Choice of Operation for Cancer of the Rectum, Dr. Turnbull.

Biologic Aspects of Cancer of the Colon, Dr. Crile.

Factors Influencing the Development of He-

(Continued on Page 1712)

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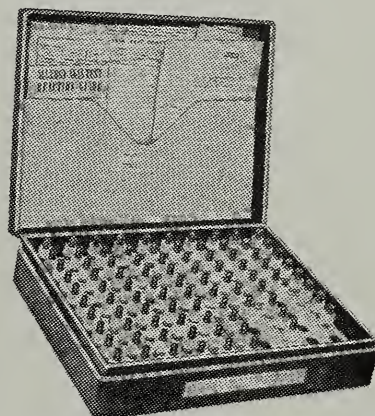
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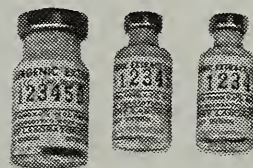
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as it calms anxiety!

Deprol helps balance the mood by lifting depression as it calms related anxiety

No "seesaw" effect of amphetamine-barbiturates and energizers

While amphetamines and energizers may stimulate the patient—they often aggravate anxiety and tension. And although amphetamine-barbiturate combinations may counteract excessive stimulation—they often deepen depression.

In contrast to such "seesaw" effects, Deprol lifts depression as it calms anxiety—both at the same time.

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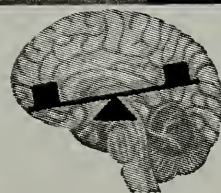
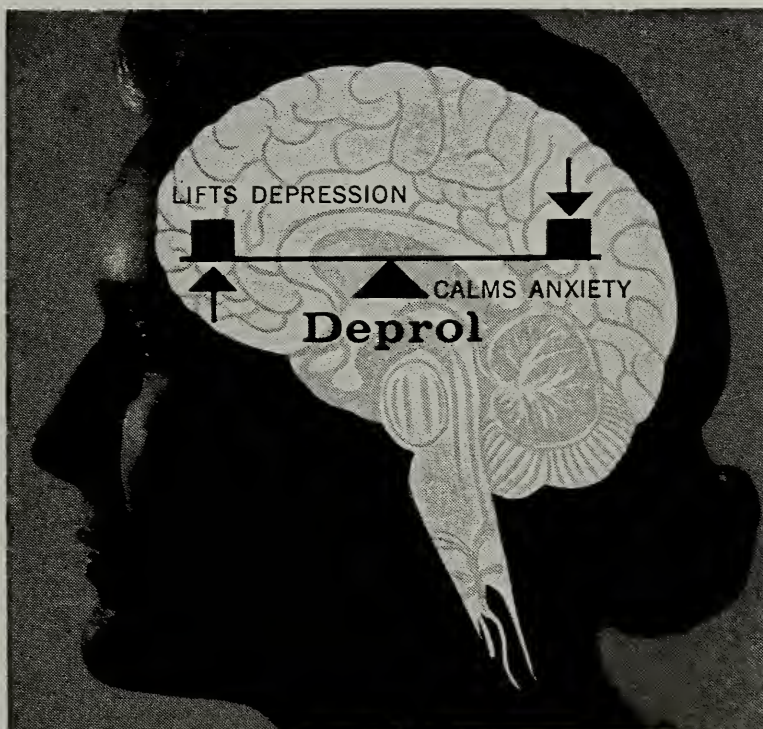
BIBLIOGRAPHY: 1. Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. *J.A.M.A.* 166:1019, March 1, 1958. 2. Bateman, J. C. and Carlton, H. N.: Deprol as adjunctive therapy for patients with advanced cancer. *Antibiotic Med. & Clin. Therapy*. In press, 1959. 3. Bell, J. L., Tauber, H., Santy, A. and Pullto, F.: Treatment of depressive states in office practice. *Dis. Nerv. System* 20:263, June 1959. 4. McClure, C. W., Papas, P. N., Speare, G. S., Palmer, E., Slattery, J. J., Konefal, S. H., Henken, B. S., Wood, C. A. and Ceresia, G. B.: Treatment of depression—New technics and therapy. *Am. Pract. & Digest Treat.* In press, 1959. 5. Pennington, V. M.: Meprobamate-benactyzine (Deprol) in the treatment of chronic brain syndrome, schizophrenia and senility. *J. Am. Geriatrics Soc.* 7:656, Aug. 1959. 6. Rickels, K. and Ewing, J. H.: Deprol in depressive conditions. *Dis. Nerv. System* 20:364, (Section One), Aug. 1959. 7. Ruchwarger, A.: Use of Deprol (meprobamate combined with benactyzine hydrochloride) in the office treatment of depression. *M. Ann. District of Columbia* 28:438, Aug. 1959. 8. Settel, E.: Treatment of depression in the elderly with a meprobamate-benactyzine hydrochloride combination. *Antibiotic Med. & Clin. Therapy*. In press, 1959.

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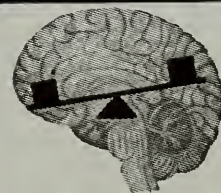
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COMPOSITION: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate.

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AMPHETAMINES AND ENERGIZERS may stimulate the patient, but often increase anxiety and tension.



AMPHETAMINE-BARBITURATE combinations may control overstimulation but may deepen depression.

(Proctology Program—Cont'd. from Page 1709)

patic Metastasis, Dr. Edwin R. Fisher, University of Pittsburgh School of Medicine.

Evening reception, Wade Park Manor, to which wives are invited.

Thursday Morning

Dr. Rupert B. Turnbull, Jr., Presiding
Pilonidal Sinus Disease and Fissure in Ano.
Dr. Crile.

Fistulas in Ano, Dr. Jackman.

Endoscopic Diagnosis of Certain Lesions of the Rectum (Movie), Dr. Jackman.

Pruritus Ani—Diagnosis and Treatment, Dr. John R. Haserick.

Nervous Symptoms Around the Anus, Dr. Leonard L. Lovshin.

Rectal and Colonic Polyps, Dr. John B. Hazard.

Familial Polyposis, Dr. J. W. Cole, Western Reserve University.

Treatment of Rectal Polyps, Dr. Turnbull.

Thursday Afternoon

Free discussion in small groups—audience and faculty.

Cleveland Company Makes Unique Gift to Medical Education

Six of the nation's medical schools this Christmas will again benefit from an unusual program of group giving, whereby a brewing company in the name of its wholesalers donates \$12,000 to the National Fund for Medical Education instead of spending that sum on individual presents for its 680 distributors. The contribution will be included in the approximately \$3,000,000 to be awarded this year to the medical schools by the Fund in unrestricted, across-the-board grants.

The corporate-giving plan was initiated last year by The Carling Brewing Company of Cleveland, with the cooperation of its distributors. The 1958 contribution totaled \$10,000; this year that amount has been increased by \$2,000.

Western Reserve University School of Medicine, Cleveland, will be one of the six medical schools to receive a check for \$2,000 from the National Fund for Medical Education in behalf of The Carling Brewing Company and its distributors in the Cleveland area.

The Fund, founded in 1949 by Dwight D. Eisenhower, then Columbia University head, former President Hoover, Dr. James B. Conant and other leading educators, channels contributions from industry to the medical schools. Since the first grants were made in 1951, it has distributed \$18,668,946.

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Supplied: Tiny 10 mg., 25 mg., and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

References: 1. Farah, L.: *Internat. Rec. Med.* 169:379 (June) 1956. 2. Smigel, J. O., et al.: *J. Am. Geriatrics Soc.* 7:61 (Jan.) 1959. 3. Feinberg, A. R., et al.: *J. Allergy* 29:358 (July) 1958. 4. Eisenberg, B. C.: *J.A.M.A.* 169:14 (Jan. 3) 1959. 5. Maryssael, L.: *Bruxelles-méd.* 38:141 (Jan. 26) 1958. 6. Pfleger, R.: *Med. Klin.* 53:1030 (June 5) 1958. 7. Over 200 laboratory and clinical papers from 14 countries.

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Too Many Beds? . . .

Article in Medical News Suggests That Perhaps Over-Building Is One of the Major Causes of Rising Hospital Costs; Solution is Recommended

A THOUGHT-PROVOKING discussion on rising hospital costs and some of the causes, including overuse of hospital facilities and unjudicious expansion in the number of hospital beds, plus suggestions on possible ways to meet the problem, was published in a recent issue of the *Ciba Medical News*, entitled "A Surfeit of Beds?"

The Journal believes the article should be digested by Ohio physicians. For that reason, it is being reproduced. Although all readers of *The Journal* may not agree with all the statements made and conclusions reached, it is believed they will admit that it gives them a jolt and sets up a warning that a solution is called for. The article follows:

Text of Article

"In what has been called 'the squirrel cage of today's medical economy,' hospital costs seem to be running faster and faster just to keep up. At present speed, there is a real possibility that hospital care may be priced out of the reach of a large segment of the public.

"Almost everyone agrees that one reason for upped rates is the overuse of hospitals, particularly for diagnostic purposes. Recognizing this, many Blue Cross and Blue Shield plans are offering coverage for services performed in doctors' offices or hospital outpatient departments.

"This is a logical line of attack against one 'rising-costs' factor. Another important factor, however, is the matter of beds.

"Traditionally, the bed question has been one of shortage. Quite recently, for example, a government official declared that despite recent years of heavy construction, we still have only three-quarters of the needed general hospital beds. He estimated we should have 880,000 more.

More Beds, More Days

"This may be, but more and more people are beginning to see the other side of the bed issue—the relationships of supply to use and of use to cost. In a recent issue of *Modern Hospitals*, Max Shain and Dr. Milton Roemer state it most briefly:

"Hospital beds that are built tend to be used."

"After charting the number of hospital days per 1,000 population against the bed supply in each state, the authors conclude that 'more than

70 per cent of the differences in hospital utilization, by state and county, are associated with differences in bed supply.' In other words, 'the more beds, the more hospital days.'

"As a corollary to this, their figures suggest that within the United States 'general hospital beds are occupied at about the same rate, regardless of whether there are few or many beds per thousand population.'

Income No Factor

"How does this work? As these authors see it, in pre-hospital-insurance days, family income determined which cases would go to hospitals. With widespread insurance, however, bed availability becomes the deciding factor. For instance, a region with few beds will fill them with serious cases; accident victims, patients with grave illnesses, those in dire need of surgery. Give the same region more beds and they will be used for 'a wide range of other conditions'—multiple extractions of teeth, psychoneuroses, and obscure diagnostic problems.

"Of course, the community gains from higher standards of health care made possible with a larger bed supply and the removal of financial barriers. But while they 'don't know what it is,' Shain and Roemer believe 'there must be some desirable limit to the bed supply.'

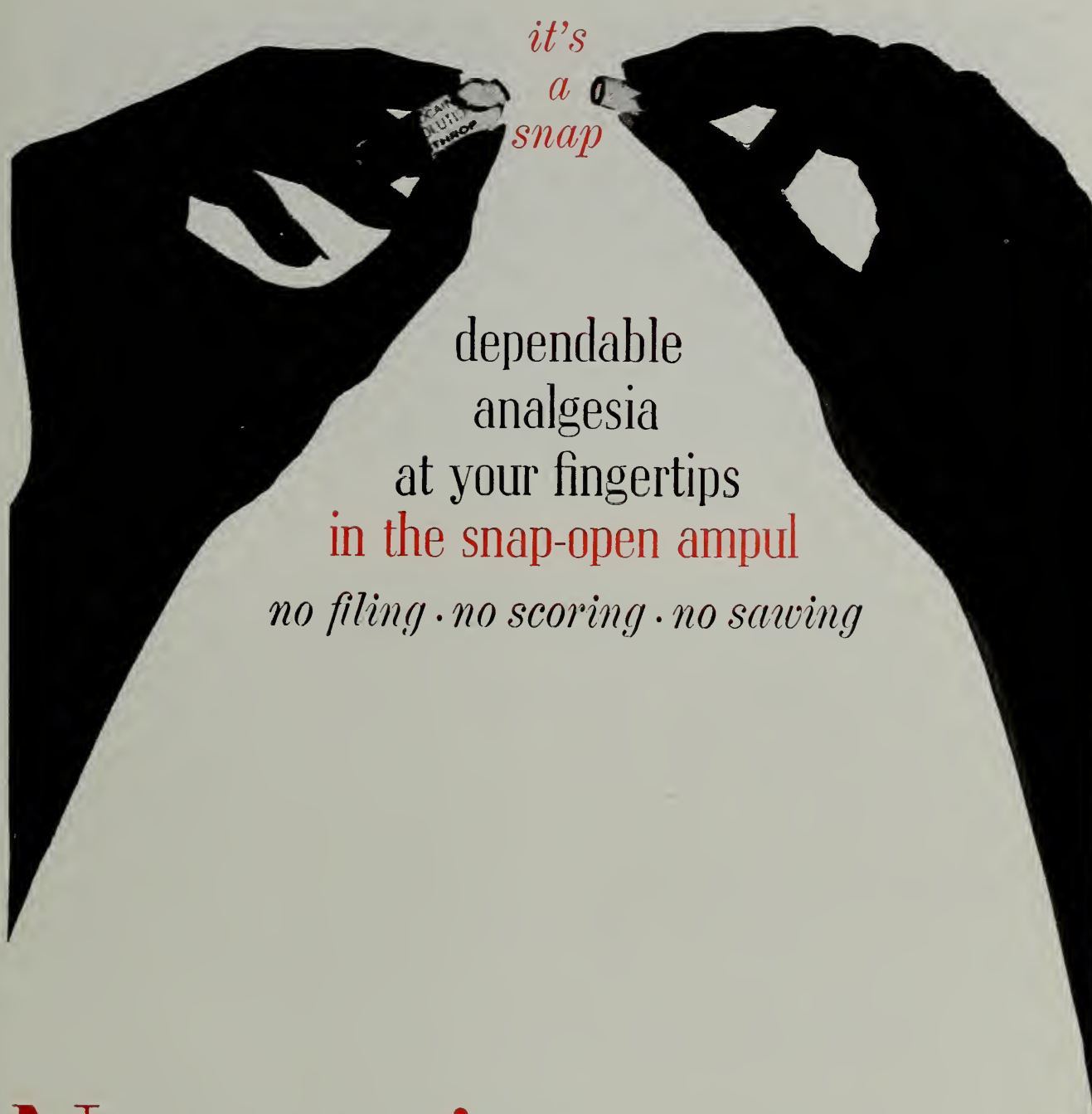
Increased Use

"A similar conclusion is voiced by Dr. Richard J. Ackart Jr. of Richmond, Va. He notes that Richmond Blue Cross costs per 1,000 members between 1955 and 1958 went up 50 per cent, while the price tag per day of care increased only 25 per cent. At the same time, 800 new beds became available to subscribers. The difference between the two percentages, he concludes, must be due to increased use—made possible in large part by the extra beds.

"Projecting these figures to 1961, Dr. Ackart predicts that 'the expense of prepayment for hospital care . . . will be almost doubled, as a result not only of increased hospital operating expenses but also of continued construction of new hospital beds.'

"Dr. Ackart doesn't suggest that the solution

(Continued on Page 1722)



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is to stop this expansion. 'Obviously the people . . . want the benefit of increased availability of hospital beds,' he says.

People Must Pay

"Unfortunately, however, few people . . . fully realize that they must also personally pay for the maintenance costs of the new beds they have brought into existence—as they use them. More beds, more use of beds, more personal expenditure. It matters not whether the expenditure is made as a postpayment or a prepayment."

"Thus, he says, 'the need to finance maintenance of a progressively increasing number of hospital beds poses the danger of pricing out of the market the heretofore successful voluntary system of paying and prepaying for hospital care.'"

Judicious Decision Needed

"He sees the answer in 'truly judicious decisions about hospital bed construction.'"

"To ascertain that the optimum number—not a superfluity—of hospital beds are constructed and maintained, and to sponsor the construction of adequate hospital accommodations for ambulatory patients, are challenging problems for the medical profession. Only by successfully meeting them can the profession keep the costs of health care from leading the country into so-called 'socialized medicine.'"

Columbus Physicians Participate In Pediatrics Program

A team of Columbus physicians, all members of the Children's Hospital staff, participated in the program of the Ninth International Congress of Pediatrics in Montreal, Canada, recently. The program announced the following doctors and subjects:

Dr. John P. Garvin, "Pre-Operative Medication in Children"; Dr. J. P. Smith, "Urological Approach to the Hypertensive Child"; Dr. H. William Clatworthy, Jr., "Hydroamniotic as an Aid to the Early Diagnosis of Congenital Obstruction of the Alimentary Tract"; Dr. E. Thomas Boles, Jr., "Biliary Tract Disease in Infancy and Childhood," also an exhibit, "The Team Approach to Burns"; Dr. Warren Wheeler, "Infections and Nursery Problems"; Dr. Robert Blizzard, "Aldosterone Excretion in Virilizing Adrenal Hyperplasia"; Dr. Martin P. Sayers, "Improving Outlook for Myelomeningoceles"; Dr. James R. Lloyd presented paper by Dr. H. D. Sirak, "Steroid Metabolism in Open Heart Surgery." Dr. Blanca Smith completed the Children's Hospital team.

Limited Ability To Carry on Normal Activity Hits One in Every Ten

Chronic conditions affecting health limit the normal activity of an estimated 17 million people in the United States, according to findings developed from nationwide household interviews conducted in the National Health Survey of the Public Health Service.

These 17 million persons, representing 10 per cent of the population, are limited in their ability to work, keep house, or pursue outside activities. A segment of this group amounting to 3 per cent of the population or an estimated 4,855,000 persons have trouble moving about or cannot move about without help. Of the latter group, about 1 million persons are completely confined to their homes.

The figures do not include military personnel or people in mental or other types of long-term institutions.

Activity limitations were reported most frequently among low income families and older people.

Among families with incomes of less than \$2,000 a year, one in every five persons had some activity-limiting condition; for those with incomes of \$7,000 or more, only about one in every 15 persons was similarly limited.

About one in every 70 children under 15 years of age was reported to have some activity limitation, whereas about half of the persons 75 years of age and older fell in this category.

The estimates are derived from interviews conducted for the National Health Survey by the U. S. Bureau of the Census with a representative sample of the population. The information recorded about individuals is confidential and only statistical totals are published.

The report is entitled "Limitation of Activity and Mobility Due to Chronic Conditions, United States, July 1957 - June 1958," Public Health Service Publication No. 584-B 11. Copies may be obtained from the Superintendent of Documents, Government Printing Office, Washington 25, D.C., at 30 cents each.

The Poliomyelitis Respiratory and Rehabilitation Center at Children's Hospital, Columbus, associated with Ohio State University College of Medicine, received a March of Dimes grant of \$57,748.00 from the National Foundation.

Dr. Walter J. Zeiter, Cleveland, was re-elected executive director of the American Congress of Physical Medicine and Rehabilitation, at a recent meeting of that organization.

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- This notable freedom from side effects endows Deaner's long-term administration with easier patient supervision, better patient cooperation, and greater safety.
- Dosage is simple—initially, 50 mg. (2 tablets) daily in the morning. *Gradually, apathy and defeat are transformed into affability and renewed interest and vigor.*

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Activities of Woman's Auxiliary . . .

CHAIRMAN PUBLICITY COMMITTEE—Mrs. W. J. Horger,
1100 Ohio Ave., East Liverpool, Ohio
(See Page 1606 for roster of officers.)

COLUMBIANA

Twenty-five members of the Woman's Auxiliary of the Columbiana County Medical Society were entertained at a tea on the afternoon of October 20, at the home of Mrs. Alfons Falkenstein in Salem. Mrs. Falkenstein presided at the business meeting when Mrs. J. R. Milligan was welcomed as a new member. Mrs. Virgil Hart introduced the guest speaker, Miss Barbara Brian, an interior decorator. Her topic was "The Use of Color in Your Home."

HAMILTON

The first fall meeting of the Woman's Auxiliary to the Academy of Medicine of Cincinnati was held on October 20 at the Western Hills Country Club. Program chairman of the day was Mrs. O. Herman Dreskin with Mrs. Lowell Colter, Jr., vice-chairman. Hospitality chairman was Mrs. Arthur Spreen and Mrs. Hobart Fullerton, vice-chairman. The speaker was Mary Louise Schum whose topic was "Your Decorator and Design for Home." Mrs. Don N. Berning, president of the auxiliary, conducted her first meeting. Mrs. William Ahlering, president-elect and membership chairman, introduced the new members.

Mrs. Norbert Cavanaugh, chairman of new members orientation, entertained the new members and officers and committee chairman at her home, on October 27. This committee was organized several years ago to help the new members to meet each other and to learn the functions of the auxiliary, so that they might become active members. Several of these informal meetings have been planned by the committee to be held throughout the year. Mrs. John Mohan is the vice-chairman.

HURON

Mrs. David Boals was hostess to members of the Woman's Auxiliary to the Huron County Medical Society on October 9 at the Elks Country Club, Norwalk. Mr. Grinnell, social worker for the Huron County Guidance Center, presented an outstanding program on mental health. Seventeen members attended.

LICKING

As guest speaker for American Education Week, Miss Meera Bai of Madras, India, addressed the Woman's Auxiliary to the Licking County Medical Society at its regular meeting on October 28. Miss Meera Bai is visiting librarian at the William Doane Library of Denison University and her stay

in the United States was arranged through the U. S. Information Service in conjunction with the Asian Studies program instituted at Denison.

Speaking on education in general and medical education in India, Miss Meera Bai also touched on the dress, social customs, and politics of her native country. Her formal remarks were followed by a question and answer period.

The medical auxiliary was especially pleased to hear this speaker as the members of the auxiliary individually and with their husbands are vitally concerned with local education and with American Medical Education. Speakers such as Miss Meera Bai give us a much needed view of medical education, training and standards, in other parts of the world.

LUCAS

Academy Blood Donor Day, October 29, the Woman's Auxiliary cooperated with the Academy of Medicine to support operation of the Red Cross Community Blood Center. Mrs. Joseph M. Hertzberg was chairman of the auxiliary activity.

Study Groups are in full swing for the coming season. In November the Travel Group, with Mrs. Wendell W. Green as chairman met at the home of Mrs. Thomas Miller. The topic of the afternoon was "Alaska." Hostesses were Mrs. Joseph M. Hertzberg and Mrs. Donald S. Booth.

The Home Clinic Group, led by Mrs. John E. Gallagher, met at the home of Mrs. David P. Wheeler with Mrs. Frank F. Snyder as co-hostess. "House Plants and Their Problems" was discussed by Mrs. Daniel Tanner.

The Intermediate Dance Group of which Mrs. Rolland E. Scherbarth is chairman began a series of weekly lessons in October.

The Bowling Group, led by Mrs. Gordon M. Todd, meets weekly; the beginner's class and refresher course in Bridge with professional instruction will start classes in January. Mrs. Wallace Morton is chairman of these groups.

Mrs. Henry P. Drake introduced Mr. Tennyson Guyer, Ohio State Senator and humorist, whose topic was "New Frontiers" at the general meeting and guest day, November 10, at the Academy Building. Mrs. Harold P. Shapiro and Mrs. J. B. Hirsch were in charge of the tea following the program.

MAHONING

On October 27 the Woman's Auxiliary to the Mahoning County Medical Society met at the YMCA for a luncheon meeting. Members of the Woman's Auxiliary to the Mahoning County Bar

Association were guests. Mrs. Robert Weimer, vice-president of the Bar Auxiliary, extended an invitation to the Medical Auxiliary to attend a tea at the Butler Art Gallery on November 18.

A panel discussion on the "Juvenile Court" followed. Members of the panel were Mrs. E. M. Thomas, Mrs. Craig Wales, and Mrs. James Smeltzer. A resumé of the book, *Sins of Their Father*, by Dr. Pittwagen was given by Mrs. Thomas; a report of the Detention Home was presented by Mrs. Wales; and an explanation of the newly formed Mahoning County Citizens' Committee on Services for Delinquent Children and Youth was presented by Mrs. Smeltzer. Auxiliary members voted a contribution to be given to the committee to aid in the financing of a survey of the Youngstown area. This survey will be conducted by the National Parole Board.

Program chairman for the meeting was Mrs. Craig Wales, assisted by Mrs. E. M. Thomas co-chairman. Mrs. Robert Brown, Mrs. Rollis Miller, Mrs. Fred Schellhase and Mrs. James Smeltzer completed the program committee. Social chairman was Mrs. Myron Hanyah with Mrs. H. S. Banninga co-chairman. Mrs. Robert Jenkins and Mrs. S. W. Chiassone assisted.

November 28 was the scheduled date of the American Medical Education Foundation and Paramedical Scholarship Fund Dance at Squaw Creek Country Club.

The Sixth District Councilor meeting was held October 21 in Warren. The women's activities for the day consisted of a coffee in the morning following registration. A punch hour preceded a luncheon for 145 at the Christ Episcopal Church. A skit and style show followed. Mrs. C. A. Columbi, state president, was guest of honor.

During the afternoon and evening a cocktail party was held at Venaro's Restaurant followed by a dinner for 700 at the Packard Music Hall.

Nineteen persons represented the Woman's Auxiliary to the Mahoning County Medical Society at the District meeting.

The next Sixth District Councilor meeting will be held in Youngstown in October 1960.

Mrs. W. H. Evans, a national director of the Woman's Auxiliary to the American Medical Association, recently returned from Chicago where she attended the National Conference of the Woman's Auxiliary to the AMA for State Presidents and Presidents-elect. She also attended a pre-conference and post-conference Board Meeting.

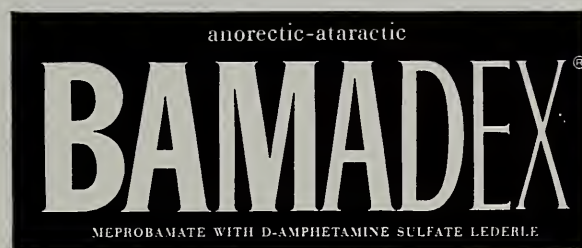
SUMMIT

The Woman's Auxiliary to the Summit County Medical Society met for Brunch November 3 at Portage Club. The speaker was Mr. Sherlock

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Holmes Evans, a trial lawyer and author of several best sellers including "Father Owned a Circus." His subject was a courageous one "How to Handle Women and Other Explosives." The members of the Dental Auxiliary were guests. President Mrs. Robert Hemphill presided at the business meeting.

UNION

The Auxiliary to the Union County Medical Society held its first meeting of the year at Memorial Hospital October 5. In the absence of the President, Mrs. James Snider, the vice-president, Mrs. E. J. Marsh, had charge of the meeting.

Two new members were welcomed into the Auxiliary, Mrs. Linscott and Mrs. Hurl. Nine members answered roll call.

Again this year the Auxiliary is supporting the United Appeals and the card party sponsored by the hospital guilds.

The meeting was then turned over to the program committee. Mrs. Angus MacIvor gave a report on the programs planned for this year. Mrs. E. J. Marsh gave a talk on the relationship between the County Auxiliaries and the State Auxiliary and the work both do.

A social hour followed the meeting.

Castoff Bone Instruments Needed In Medical Mission Field

Used vitallium bone instruments are badly needed by a medical missionary in Africa, according to information received by *The Journal* from an Ohio physician.

Particularly needed are femur guidepins, Kunscher clover-leaf-type medullary nails, Smith-Petersen nails and assorted plates and screws.

Rarely used by American surgeons the second time, it is requested that these discarded second-hand splints be sent to: Rev. Harold Behle, Navarre, Ohio. He will forward them to the medical mission in Africa.

Apologies To Cincinnati Speakers

In reporting the meeting of the Northwestern Ohio Medical Society at Findlay on October 7, *The Journal* stated that the program was presented by a team from the Ohio State University College of Medicine. This was only partially correct as speakers from the University of Cincinnati College of Medicine presented part of the program. *The Journal* regrets having made this error.

A seminar on "Peripheral Vascular Diseases" was presented by the Southwest Ohio Society of General Physicians at the Good Samaritan Hospital in Cincinnati, October 14 and 15.

Want To Promote Keogh-Simpson Bill? Here Are Films To Help Do So

Three films, available on a loan basis give different slants on provisions of the Keogh-Simpson Bill (H. R. 10), the plan to give self-employed equal treatment with the employed in setting aside tax-deferred sums for retirement. The films are designated by names of those who participate in discussion in respective films.

Smathers: Ten minutes running time, color film, 16 millimeters. The Florida Senator, who is a co-sponsor of this legislation and a member of the Senate Finance Committee, is interviewed by two members of press. This session on H. R. 10 is lively and informative.

Moss-Smathers: Ten minutes running time, black and white, 16 millimeters. The Senator from Utah and Senator Smathers highlight the merits of the bill in their discussion.

Allott-Simpson: Ten minutes running time, black and white, 16 millimeters. Senator Allot (Colorado) has as his guest the Republican co-sponsor of H. R. 10, Rep. Richard M. Simpson of Pennsylvania. Mr. Simpson explains why he feels that this legislation is essential.

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American Diabetes Association Names Dr. Striker

The American Diabetes Association has named Dr. Cecil Striker, Cincinnati, as governor for the State of Ohio for a three-year term, to expire in June, 1962.

A few years ago the American Diabetes Association with offices at 1 East 45th Street, New York 17, established a Board of State Governors similar geographically to that of the American College of Physicians. Purpose of the new organization is to facilitate coordination of activities in the field and to stimulate interest in diabetes and related conditions.

Two other Ohioans have key posts in the national organization. Dr. Thomas P. Sharkey, Dayton, is treasurer, and Dr. Harvey C. Knowles, Jr., Cincinnati, is a member of its council.

The July, 1959 issue of *Guide Lines*, a publication of the American Nurses' Association, is a civil defense issue devoted to news of what is being done by professional nurses in planning for nursing service in event of disaster.



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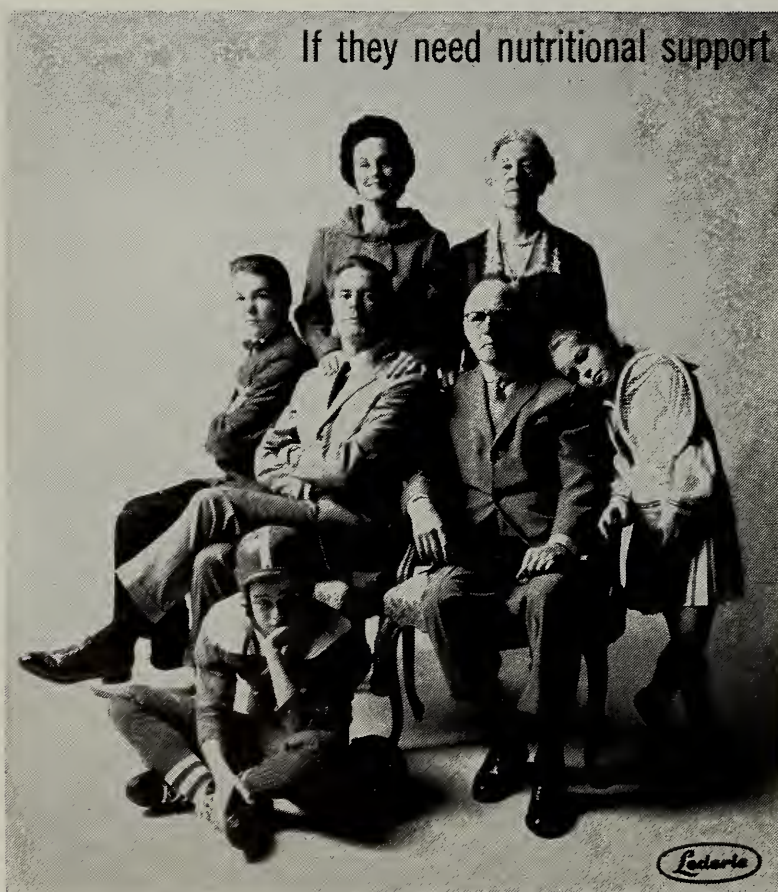
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PR at Your Fingertips. Bibliography lists AMA booklets, publications, radio transcripts, films and other material available. Write Communications Division, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

Around-the-Clock Aids for the Child with Muscular Dystrophy. Designed for basic, helpful guidance for parents caring for homebound dystrophic children. Suggestions, hints help to simplify daily routine. (25 cents) Write Medical Department, Muscular Dystrophy Asso-

ciations of America, Inc., 1790 Broadway, New York 19, New York.

The Ancillary Worker in Ophthalmological Medical Practice: Part 1—The Optician. Discusses role of optician in the total ophthalmological care of the patient. Write National Medical Foundation for Eye Care, 250 West 57th Street, New York 19, New York.

Roentgens, Rads and Riddles. Report of symposium on supervoltage radiation therapy held at Medical Division, Oak Ridge Institute of Nuclear Studies, July 15-18, 1959. (\$3.50) Write Superintendent of Documents, Government Printing Office, Washington 25, D. C.

How Retarded Children Can Be Helped. Points out recent discoveries indicating more of the retarded can be trained and educated than previously indicated. Refutes number of "old wives" tales. (25 cents) Write Public Affairs Pamphlets, 22 East 38th Street, New York 16, New York.

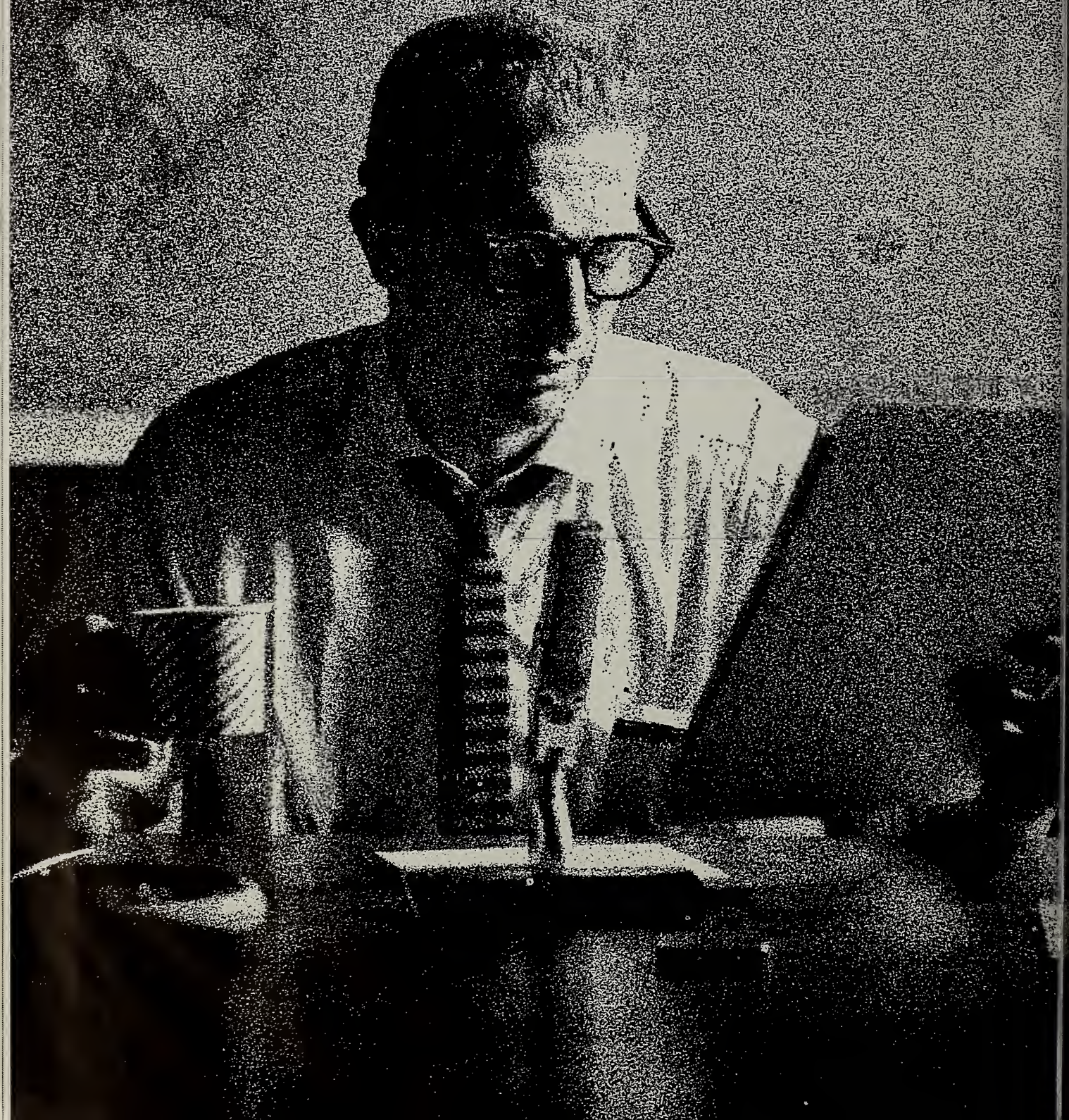
Tips on Athletic Training. Covers sound practices in diet, sleep, training practices for the school athlete, including adverse effects of drugs and smoking. Write American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

Poison Information Centers in Ohio

These centers have agreed to cooperate in a program to extend their services to any physician requesting information from them. When a center is called the physician should have four basic facts in mind: (1) The full name or brand of the product ingested or inhaled; (2) An accurate estimation of the amount of the particular agent ingested; (3) The time of ingestion; (4) The age and weight of the patient.

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The leading site of cancer today is the colon and rectum. In 1958, 58,000 new cases were diagnosed.

The present 5-year survival rate for these cancers is less than 30%. This figure could be greatly increased by closing the very wide gap between *actual* and *possible* survival rates.

Earlier diagnosis is an immediate requirement. The American Cancer Society constantly stresses the importance of annual health checkups for all adults, and urges physicians to employ digital and proctoscopic examination of the rectum and colon to find cancer in an early stage.

With your assistance, doctor, in persuading patients to accept these uncomfortable, time-consuming procedures, the gap between actual and possible survival rates could be rapidly closed.

AMERICAN CANCER SOCIETY



Ohio Division, Inc., 2185 East 14th Street, Cleveland 15, Ohio

COMING MEETINGS

Ohio State Medical Association, 1960 Annual Meeting, Cleveland, May 17-19.

Frank E. Bunts Educational Institute, Cleveland Clinic, Proctology Program, January 13 - 14.

Ohio State University Department of Ophthalmology, Postgraduate Course, Columbus, March 7 and 8.

Ohioans Will Participate on Phase Of Cancer Prevention Study

Ohio will participate in a nation-wide medical statistical study designed to discover why some people may be more likely to get cancer than others, it was disclosed by Dr. Arthur G. James, president, Ohio Division, American Cancer Society.

The project, known as the Cancer Prevention Study, will require the assistance of more than 5,700 trained volunteers in this state and will take six years to complete. All County affiliates of the society will take part in Ohio. The study will probe the effect of environment on cancer and will attempt to learn more about symptoms of the disease to help improve early detection.

The information to be obtained is designed to test many theories about the cause of cancer as well as clarify certain known facts about the disease. Some of these include: occupational hazards in relation to cancer; whether or not a tendency toward cancer is more prevalent in some families; what relationships exist between cancer and other diseases; whether frequency and other factors of childbirth are associated with cancer; how much relationship there is between failure to breast feed a child and the occurrence of breast cancer; possible relationship between menstrual disorders and uterine cancer; any relationship between diet, beverages, exercise, smoking and cancer; how air pollution may be related to cancer; whether or not one's standard of living has anything to do with his getting cancer.

In Ohio the project will attempt to study 58,000 families, totalling about 116,000 persons who are at least 30 years of age. Each volunteer researcher will select about ten households which he can expect to trace for the following six years. These families will be reported on annually. At the start of the study, every person enrolled will answer a detailed, confidential questionnaire. Every two years, they will be asked to fill out a brief questionnaire, Dr. James explained. In the event of death, the cause will be ascertained from death certificates and medical records.

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